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OVERSIGHT ON VA HEALTH-CARE FUNDING

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

APRIL 6, 1989

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OVERSIGHT ON VA HEALTH-CARE FUNDING

THURSDAY, APRIL 6, 1989

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The committee met, pursuant to notice, at 8:03 a.m., in room SR-418, Russell Senate Office Building, Hon. Alan Cranston (chairman of the committee) presiding.

Present: Senators Cranston, Graham, and Jeffords.

Also present: Senator Cohen.

OPENING STATEMENT OF CHAIRMAN CRANSTON

Chairman CRANSTON. Good morning. We thank you all for being here at this early hour.

I welcome you to today's oversight hearing, in followup to our hearings last September on the state of funding for the VA's health care system and to our March 6 budget hearing. My longer statement is available at the press table.

[The prepared statement of Chairman Cranston appears on p. 99.]

Chairman CRANSTON. In September, just prior to the current fiscal year, we heard very compelling testimony about the severity of the problems facing the system and predictions about how the budget woes would affect the quality and quantity of VA care in fiscal year 1989. Today's hearing, as we have just passed the halfway mark of the fiscal year, should give the committee the opportunity to update that earlier information as we go forward in the all-important budget and appropriations processes.

I am convinced that we need both major supplemental funding for the current fiscal year as well as significantly increased funding levels for next year. In both cases, we need funding well beyond the level requested by the administration for fiscal year 1989 and fiscal year 1990. The lack of adequate funding is the most pressing problem in the VA system today.

As chairman of this committee, I have made efforts to restore adequate funding for VA health care a top priority. Last September, VA medical center directors, doctors, and nurses virtually unanimously described under the oath, the situation then as a "crisis," and, "the worst financial crunch," that they had ever seen in VA health care.

Today, we seek to learn how, if at all, things have changed since then, and about the impact on individual veterans seeking VA care.

Early this year, I wrote to VA directors of more than 50 VA medical centers, asking them to provide copies of all issuances relating to reductions in services or program changes due to the budget shortfall, and to provide quarterly updates. I have forwarded the material we received to the Senators from those States.

The 41 replies thus far show a continued erosion in VA health care. Thousands of veterans are being told, after years of receiving VA care, to go elsewhere, or that they must wait longer periods of time—in many cases, a denial of care, in and of itself—before receiving certain types of care or prostheses.

Numerous programs and services are being cut back or eliminated altogether, including home-care services, alcohol and drug treatment centers, and VA and community nursing home care, to name just a few. Over one-third of the responding facilities have cut off inpatient or outpatient care or both for veterans who are not in category A.

Our March 6 budget hearing highlighted many acute VA health care problems: inadequate funding for staffing, for research, for equipment, and for supplies, as well as cuts in the services provided to veterans. There is growing concern across the system that despite the best of intentions, the quality of VA care is suffering as a consequence of the budget shortfall. That simply cannot be allowed to happen without every effort being made to correct the situation.

In response, our committee, on March 8, recommended to the Senate Budget Committee, $618.4 million in supplemental fiscal year 1989 VA medical care funding, and an additional $1.24 billion for fiscal year 1990 over the administration's request for VA medical care. These increases are needed to restore patient workloads and health-care staffing to approximately fiscal year 1988 levels and to begin making the efforts necessary to deal with the growing needs of veterans for long-term care, the enormous unmet needs of Vietnam veterans for PTSD treatment, the escalating demands for and cost of AIDS treatment, the great numbers of homeless veterans, and the need to fight the epidemic of drug and alcohol abuse.

Less than 2 weeks ago, on March 24, the Bush administration finally—after half the fiscal year has already passed—submitted a supplemental fiscal year 1989 VA medical care request. The amount requested was $303 million—too little, too late. No increase was proposed for fiscal year 1990. I will continue my work for higher funding levels.

I expect this hearing to help in those efforts, and I want to thank all of today's witnesses for their willingness to come forward and share with us their personal and professional views of what is going on in VA's health-care system.

In closing, I want to note two positive developments. First, at my request, the VA, on March 13, directed all field facilities to resume providing nonprescription drugs and items as needed to all. Second, Secretary Derwinski has directed that until further notice, closure or reduction of VA substance abuse programs will no longer be left to local discretion and that all VAMC policy changes with potential impact on access to nonemergent care will henceforth require his approval.

Finally, we will be placing all witnesses under oath today, and I want to explain why. VA staff members who have appeared before our committee are a talented, highly professional, and honorable group of individuals. Administering the oath is in no way intended to impugn any witness' integrity. The background of this matter pertains to representations at our committee's March budget hearings last year, that the administration's budget for fiscal year 1989 contained ample resources for the VA to care for all eligible veterans who were expected to apply for and be in need of health care.

Within a matter of months, however, it became clear that even with the $215 million that Congress added to the medical care account, the VA health-care facilities were facing a dire financial crisis in fiscal year 1989. Hence, to provide a form of protection to VA witnesses from Central Office and field stations in order to get firsthand, candid impressions of the situation, I decided to require all witnesses at our committee's September 9 oversight hearing to testify under oath.

In stark contrast to the earlier overly-optimistic picture, we heard in September a shocking portrayal of a system clearly unable to provide needed care to many thousands of veterans. I have since received several comments that the oath contributed significantly to the candor and openness so evident on that occasion. Consequently, for the foreseeable future, all committee budget hearings as well as oversight hearings with VA field personnel will take testimony under oath, as we did at our March 6 budget hearing.

I want to apologize to all the witnesses and our other committee members for the last-minute switch in the starting time of this hearing. I assure all concerned that it was necessary in view of another committee meeting that was scheduled yesterday for this morning, which I must attend at 10 a.m.

We have a statement from Senator DeConcini to be included in the record.

[The prepared statement of Senator DeConcini appears on p. 103.]

Chairman CRANSTON. Senator Jeffords, I welcome you at this early hour, also. Do you have any opening statement to make?

OPENING STATEMENT OF SENATOR JEFFORDS

Senator JEFFORDS. I do, Mr. Chairman, and I will just put it into the record at this point, with your permission. I would just like to say that I deeply appreciate these hearings.

We will have the good Vermont director here shortly, and I am here to listen to all of the panels. I deeply appreciate your opening statement, which was right on. Thank you.

[The prepared statement of Senator Jeffords appears on p. 104.]

Chairman CRANSTON. Thank you very much. I appreciate your vigorous activities on this committee and your support.

We will now hear from our first panel, composed of veterans' organization's service officers from the field. Let me welcome our witnesses: from the Veterans of Foreign Wars, Alfred Simmons, a Service Officer in Baltimore, and Robert Newsome, a Service Officer in Alexandria; from the Disabled American Veterans, Jerry Cox, a Service Officer in Philadelphia, and Larry Dawson, a Service Officer in Phoenix; and from the Paralyzed Veterans of America, Richard Woodworth, a Service Officer at Nashville. I am not sure that the VFW witnesses have yet arrived.

We welcome you this morning and thank you all very much for helping in preparing for this hearing. We have your prepared statements, which are very informative. They will appear in full in the record.

[Witnesses sworn.]

Chairman CRANSTON. We will now begin with Mr. Cox of the DAV. Would you please summarize in 5 minutes, as we will be asking each witness to do. I do have to leave at 10 o'clock, and I want to complete our business by then.

TESTIMONY OF JERRY D. COX, SUPERVISOR, NATIONAL SERVICE OFFICER, DISABLED AMERICAN VETERANS, PHILADELPHIA, PA

Mr. Cox. Thank you, Mr. Chairman.

During the past few weeks, I have had the opportunity to talk with many Veterans 'Administration medical personnel in the Philadelphia and Pennsylvania areas. The question put to each of these directors was: was the budget given to the VA medical centers sufficient to run their operations? What came out of these discussions was a feeling of hopelessness among many VA employees.

Each of the VA medical centers in Pennsylvania will suffer with a budget shortfall for fiscal year 1989. The range runs from $200,000 to $1.8 million. In order to adjust to this crisis, steps were taken by the medical centers to reduce services in order to work within the available funding.

One such area, which was hard hit, was staffing. One medical center was funded for 1,099 full-time equivalent personnel, which is a reduction of 28 positions from last fiscal year. At the moment, they have a ceiling of 1,133, which equates to 34 above the target. In order to come down to target level, the medical center has implemented an employment freeze. This will, of course, have a long-run effect on medical center operations.

An example of this is the Engineering Service, which has over 10 positions being frozen. This means that equipment is not being checked as often and maintenance of buildings and grounds is at a reduced level. This will result in equipment breakdown more often, and ultimately will cost the system more.

In checking with other medical centers, all agree that engineering services, janitorial and other housekeeping services, will be strongly affected by lack of staffing.

When these types of services are cut, the following occurs. On February 2, 1989, one of our veterans reported to one of the VA medical centers for a scheduled examination on his service-connected disability. Upon arriving at the facility, he checked in with the VA personnel in the waiting room and then proceeded to the one and only public restroom in the waiting room area.

What the veteran found was appalling. The bathroom was filthy. Blood was on the floor, toilet facilities, and what appeared to be vomit was around the area. The veteran left the area and reported this finding to the VA staff on duty. He was informed that the area would be cleaned.

Three hours later, when the man left the hospital, the restroom had yet to be cleaned. Mr. Chairman, I do not have to remind you of the diseases that can be transmitted through such an unhealthy environment.

The lack of sufficient funding and how it affects staffing can affect veterans in other ways. For example, one medical center has a post-traumatic stress disorder ward with a 51-bed capacity. This ward is where the most chronic cases are admitted for treatment and care.

Regrettably, only 30 beds are in use, and as of March 10, 1989, there was a waiting list of 38 individuals waiting for admission. Keep in mind that these are the truly chronic cases, the ones that should be in the hospital this very minute. Once again, it was indicated that the waiting list existed due to staffing shortages.

In talking with one hospital director, he indicated that he had a total of 412 beds. However, he could only operate 325, and even if the 325 beds were at full capacity, his staff would be stretched to the extremes.

Another hospital director has 917 beds and is operating only 353. In Philadelphia, the new 240-bed nursing home will be completed this summer. Funds that were set aside for the nursing home had to be used to run the VA medical center.

When the nursing home opens, money will be taken back from the hospital resulting in additional shortages for the hospital and reductions in services. Even with what funds the nursing home will have, they will not be able to open to full capacity due to staffing shortages within the nursing ranks.

Another area of concern is the length of time it takes to be seen by a specialist in a given field after an appointment has been made. At one medical center, there is a 6-month delay in securing an appointment with an eye or orthopedic clinic. The norm for specialty clinics seems to be approximately 3 months.

At times, appointments are doubled up and, at one facility, morning appointments are scheduled when the doctors are not available until 1 p.m. What occurs is that veterans are not seen by doctors by closing time.

On December 21, 1988, an incident occurred when the clerical staff knew that the orthopedic doctors would not be available for the entire day. The veterans who had appointments were not told until some 5 hours later. Whether this occurred due to poor supervisory management, complacency on the part of the employees, or lack of proper staffing is anyone's guess.

Another concern to hospital administrators is whether or not their hospital could pass a review by the Joint Commission on Accreditations. Many VA medical centers work closely with local medical schools. These schools demand and deserve to know that the doctors which they produce are trained in facilities which meet the highest of standards. Without proper funding, contracts with these medical schools could be in jeopardy.

Chairman CRANSTON. If you could summarize, sir. The red light is on.

Mr. COX. Yes, sir.

There have been several other areas which have been affected due to staffing shortages. Nursing home placements have been cut from 6 to 3 months. Other areas that they are looking to cut are closing day treatment centers and eliminating outside contracts to conduct medical tests which the VA medical centers cannot handle.

When a budget deficit occurs in the Veterans Health Services and Research Administration, a domino affect also occurs, which affects the Veterans' Benefits Administration. This, of course, causes aggravation upon the veterans and a bleak financial outlook.

In March 1988, the turnaround time for rating examinations in the Wilkes-Barre VA Medical Center was 62.9 days. This has steadily increased to the point that as of January 1989, it had risen to 89 days.

The Veterans' Administration Health Care System in Pennsylvania has an awesome responsibility, Mr. Chairman. That is, to provide the best quality of service to the 1,508,000 veterans in Pennsylvania. Without your support, the health care system will only decline further and, in the end, this Nation's veterans will be the ones to suffer.

[The prepared statement of Mr. Cox appears on p. 112.]

Chairman CRANSTON. Thank you very much.

Senator Graham, I welcome you at this early hour. Do you have any opening remarks you would like to make?

OPENING STATEMENT OF SENATOR GRAHAM

Senator GRAHAM. Mr. Chairman, I appreciate your holding this hearing, which is both timely, in terms of the prospect that we may soon be considering the recommendation for supplemental appropriation, and also urgent, given the scale of the crisis in access in service for Veterans' Administration medical care.

Mr. Chairman, I have a written statement that I would like to file for the record. Incorporated in the statement is a summary of the hearing that I held in Orlando last week, at which similar statements were made relative to veteran health-care needs.

[The prepared statement of Senator Graham appears on p. 105.]

Chairman CRANSTON. Thank you very much, and we are deeply grateful to you for conducting that hearing and for the efficient way that you are sharing your findings with us. Thank you very, very much.

Mr. Dawson, will you please proceed next?

TESTIMONY OF LARRY J. DAWSON, SUPERVISOR, NATIONAL SERVICE OFFICER, DISABLED AMERICAN VETERANS, PHOENIX, AZ

Mr. DAWSON. Thank you, Mr. Chairman. I would like to thank you for this opportunity to appear before you on behalf of the 22,000 members of the DAV in Arizona, as it pertains to health care for the veterans in our great State.

Mr. Chairman, we have been inundated with calls from veterans being treated at the three VA medical facilities, based on the drastic curtailment of care, extreme delays, and in some cases, even refusal to provide medical care. At the current time, we are observing ward closures, clinic closures, loss of ability to provide surgical procedures, drastic curtailment of prosthetic aids as well as pharmaceutical needs. It is clear that the funding deficiencies are contributing greatly to our situation, as is the high influx of winter visitors and the growth of the population of Arizona in general.

Like Mr. Cox, we have contacted hospital directors and been in close communication with them over the situation. The Tucson Veterans' Administration facility, since 1985, has shown an increase from 150,000 to 175,000 outpatient visits on an annual basis.

Based on this increase, specialty-level clinics have from a 4- to 6-month waiting period before a veteran may be seen. Budget restraints in this hospital are creating a tremendous problem with equipment. At the current time, a 10 times greater budget is needed just for maintenance and replacement of equipment than what is actually budgeted.

The Phoenix VA hospital, while being able to continue treatment of all categories of veterans has been overwhelmed by veterans with legal entitlement alone. The current population of the State and their treatment of veterans—the VA Hospital in Phoenix is now treating 180,000 veterans on an outpatient basis annually in a space that was originally designed for no more than 60,000.

This facility, at the very least, should be treating over 250,000 outpatients annually. At the current time they are providing care to about 6 percent of their catchment area, while the national average is at about 10 percent.

The specialty clinic waiting list at this facility is running anywhere up to 9 months for specialty-level examinations. While the director feels that they have not hit the wall on lack of beds, he knows that there are serious times ahead.

Prescott VA medical facility has had its surgical ward completely closed. At the current time, there is only one surgeon on staff to handle emergency situations. All other surgical procedures are being referred to Phoenix and Tucson VA medical facilities.

In May 1989, a new 60-bed nursing home will be completed at the Prescott facility, however, they do not anticipate being able to open this facility within the next year. This nursing home was expandable to 120 beds, but right now, they do not have the funds for equipment, nor the staffing.

As you know, Mr. Chairman, the medical facilities have a minimum and maximum budget to deal with as well as a headcount ceiling. Sometimes, a diversion of funds will allow help in another area.

However, the restrictions on when and how these funds may be divided makes this difficult. It would seem that more responsibility in the management of the hospital should be placed in the hands of its directors, as they are normally the best suited to determine where assistance is most needed.

All three center directors have addressed this item as among their concerns. This must, of course, be done with no disruption of service or provision of health care to eligible veterans.

Another area of concern was the bonus program for physicians in the past, which is due to expire in the next couple of years. A large number of physicians at the end of this bonus era will have funds converted into accounting for the final retirement package. When this occurs, we can foresee a potentially large exodus of physicians.

In closing, Mr. Chairman, I wish to advise you of the continued cooperation and dedication of the medical facility personnel in Arizona, and I wish to thank you for giving me this opportunity to appear and testify today.

[The prepared statement of Mr. Dawson appears on p. 121.]

Chairman CRANSTON. Thank you very much, Mr. Dawson.

Next, we will hear from Mr. Woodworth of the PVA. I understand congratulations are in order, that you and your wife have just expanded your family. I hope that they are both doing well.

TESTIMONY OF RICHARD WOODWORTH, SENIOR NATIONAL SERVICE OFFICER, PARALYZED VETERANS OF AMERICA, NASHVILLE, TN

Mr. WOODWORTH. Thank you, Mr. Chairman.

My name is Richard Woodworth. I am a Senior National Service Officer with Paralyzed Veterans of America, serving at the Memphis, Tennessee Department of Veterans' Affairs Medical Center.

I am honored to be here today, as I consider this to be an opportunity rarely afforded to the average citizen. Normally, this should be an auspicious occasion. However, due to the lack of funding for Veterans Health Services and Research Administration, it is a very solemn time for me. In addition to my comments here today, I respectfully request that my written statement be reviewed and submitted for the record, as it contains evidence that will not be given in my oral statement.

The lack of funding for the Veterans Health Services and Research Administration is reaching crisis proportions, and building as we speak. In the short time allotted to me, I cannot speak for all veterans, only for the 1,500 or so that I have served since my arrival at the Memphis DVA Medical Center last June.

My 3 years as a service officer in a DVA regional office, with weekly visits to a medical center, did not prepare me for the problems I have encountered since my arrival at the Memphis DVA Medical Center. I speak to you today, not only as a service officer, but as a service connected veteran as well.

As a service officer in a DVA medical center, I talk to hundreds of veterans and their families each and every month. I am taking what time I have, not to discuss my own problems, but to tell you about just a few of the examples of the problems that the lack of adequate funding is causing for many of the veterans that I represent.

I want to tell you about veterans like Mike Williams, who is a service-connected quadriplegic. Mike lost the total use of all his limbs in the defense of his country. Mike is totally dependent on his wife Jackie.

In addition to the loss of use of his limbs, Mike has lost the use of his bladder and must wear an indwelling catheter. In a cost-saving measure, the Memphis DVA Medical Center pharmacy as well as many others, has changed the brand of catheters that they now supply to Mike and thousands of veterans like him.

This new catheter is a few cents cheaper, but deadly. This particular brand of catheter, not only is subject to leakage, but its very design causes urine to back up into Mike's kidneys. This is not just a mere inconvenience to Mike and the thousands of veterans like him. It is a life- threatening situation.

Mike's life is in jeopardy every day just so the pharmacy can save a few dollars, and they do. But in actuality, the cost of issuing a cheaper catheter is a tremendous expense to the overall hospital budget. In the end, it costs thousands of dollars for hospital care when Mike gets infections due to, yes, a cheaper catheter, but an inferior catheter.

These infections result in hospital admissions for up to 3 or 4 months at a time. Did we save any money by giving Mike a cheaper catheter? I do not think so.

When Mike goes into the hospital, we ask him to risk his life again. The medication Mike takes builds to toxic levels if not properly monitored at peak and trough levels by blood analysis. Yet in Memphis, the hospital cannot possibly monitor Mike's peak and trough levels, as they are seven FTEE lab techs short.

What lab techs they do have can only draw blood as soon as they get to each particular patient. I can also tell you that if funds are not appropriated immediately, the Memphis DVA Medical Center will lose 120 employees before the end of this month. I ask you on behalf of Mike, don't take his life.

Then there are veterans like Louis Parks. Louis is service-connected for post-traumatic stress disorder, diabetes, hypertension, and degenerative arthritis.

On February 13, Louis was told by his physician, that due to his hypertension, he needed to be admitted to the DVA Hospital and that it was a matter of life and death. He was told that he should go to the admissions office the following morning for an emergency admission. He did as he was told, and the following morning, he waited for 3 to 4 hours with his wife in the admissions waiting area. He waited for an available bed.

The clerical staff knew he was there, but did not speak to him during his wait. Due to the very nature of his PTSD, he could not wait. He became angry and uncontrollable and left the hospital, walking with two canes and long leg braces on both legs, in the rain.

Vera, his wife, followed him for over a mile in their car before she could even calm him enough to get him in out of the rain. Louis vowed to Vera and myself that he would never return to the Jackson DVA Medical Center as long as he lived. He kept that vow.

He was brought to the emergency room a month ago Wednesday, and pronounced dead on arrival. His funeral was held 3 weeks ago yesterday. Due to the lack of funding, Louis had to wait. Then due to his disability, he ended up waiting until his death.

Many of this Nation's veterans have died while serving their country in just about every foreign land and distant shore. Those who survived—many with war-related injuries—are again being asked to assist their Nation in a time of crisis. Once again, we are being asked to place our lives in jeopardy, not to support democracy, but to support budget cuts and save money—money that my written statement will prove is not saved, but is rather spent foolishly by trying to save.

Many of us who bore the brunt of the battle during the wars and the conflicts are now being asked to bear the brunt of budget cuts. Many of us expected to lose our lives in those distant lands and foreign shores. After all we have endured, overcome, and suffered, in God's name, don't take our lives at home.

Thank you on behalf of Mike Williams, Vera Parks, myself, and hundreds of other veterans that I represent. I will be happy to respond to any questions you might have.

[The prepared statement of Mr. Woodworth appears on p. 124.]

Chairman CRANSTON. Thank you very much. I appreciate your testimony. That is certainly a moving and shocking story about Louis Parks and others. We appreciate your testimony very much.

We now have the VFW witnesses. Would you please rise so I can administer the oath as I have done for the others who are here?

[Witnesses sworn.]

Chairman CRANSTON. Please proceed.

TESTIMONY OF ALFRED SIMMONS, SERVICE OFFICER, VETERANS OF FOREIGN WARS OF THE UNITED STATES, BALTIMORE, MD

Mr. SIMMONS. Mr. Chairman and members of the committee, thank you for this opportunity to present the views of the Department of Maryland, Veterans of Foreign Wars of the United States on medical care for veterans. In this regard, Mr. Chairman, it is of paramount importance for the Department of Veterans Affairs to be able to affect a hospital care system that guarantees adequate medical treatment for all veterans. To do anything less would be a breach of the faith veterans have placed in our Government.

Through the years, the budget for the Department of Veterans Affairs has not kept pace with the growing need for medical care for an aging veteran population. With the average age of the World War II veteran approaching 69 years, it is logical to conclude that the need for acute and custodial care will increase incrementally.

It would be ideal if the Department of Veterans Affairs would provide medical care to all veterans on demand. However, that is not the case.

Budget restraints and cutbacks have reduced or eliminated medical care for certain veterans whose disabilities are nonservice connected. Now these veterans are subject to an eligibility assessment based on annual income because of those restraints and cutbacks.

Veterans in this category are referred to as discretionary care patients. Discretionary care patients are provided medical care on a resources-available basis. This includes hospital care, outpatient treatment, and nursing home care.

In preparing for this hearing, I contacted the medical centers in Maryland to determine the impact budget restraints have had on discretionary care. Fortunately in Maryland, all veterans are being treated on their initial visit to outpatient clinics. Unfortunately, many veterans who require follow-on treatment, hospital care, or nursing home care are referred to public and private medical facilities.

In all instance, veterans are charged the Medicare deductible if their annual income exceeds the threshold for their category.

While this deductible per year may seem negligible for many Americans, it is an unnecessary expense for veterans who expect and deserve to have no-fee medical care.

Mr. Chairman, the problem with discretionary medical care is the uncertainty as to who is going to be treated when. The effected veterans cannot afford private medical care. If they could, they would not turn to the Department of Veterans Affairs. Their income is too large for Medicaid and too small to afford medical insurance, such as Blue Cross and Blue Shield.

These veterans reach this dilemma in the autumn of their lives, when they require the most medical care. This is surely the time that the Government should do everything in its power to assure that these veterans are not disappointed by the medical care they receive.

Mr. Chairman, this concludes my statement. I wish to thank you and the members of the committee for holding this hearing, thereby demonstrating your commitment to enhance the provisions of service to veterans by the Department of Veterans Affairs. Thank you.

Chairman CRANSTON. Thank you very much for that helpful testimony.

Mr. Newsome, were you going to testify also?

Mr. NEWSOME. Yes, sir.

Chairman CRANSTON. Please proceed.

TESTIMONY OF ROBERT A. NEWSOME, SERVICE OFFICER, VETERANS OF FOREIGN WARS OF THE UNITED STATES, ALEXANDRIA, VA

Mr. NEWSOME. Mr. Chairman and members of the committee, on behalf of the veterans of the Commonwealth of Virginia, my name is Robert Newsome and I work for the Department of Veterans Affairs, the Commonwealth of Virginia, and I am also the Department Service Officer for the VFW.

The Secretary of Veterans Affairs said that he would rather hear from the field than to hear carefully prepared bureaucratic statements. Believe me, Mr. Chairman, this is not a carefully prepared bureaucratic statement. These are facts that I deal with every day in trying to get treatment for our veterans.

The veterans health-care facilities in the Commonwealth of Virginia, Mr. Chairman, have a serious problem with shortfalls within their budgets in its hospitals, such as the one in Martinsburg, WV, the one in Mountain Home, TN, and the one in Durham, NC. The new Secretary said that in the next 6 months the Department of Veterans Affairs would undergo restructuring so that we could be proud of the Department of Veterans Affairs, but he cannot do this without the necessary funds.

The Secretary said his office is open to all elected and appointed officials from the service organizations. I plan to meet with the Secretary just as soon as time will permit.

Mr. Chairman, I have veterans in my area who are not receiving the A, B, or C category in most cases. I have a veteran in a nursing home in Staunton—we put him in because he had a stroke and needed acute care. We got him in a VA contract facility for 6 months. I could not get that extended for another 6 months or another 3 months.

His wife had to sell the farm that had been in the family for over 100 years to pay his nursing home care. I for one, do not feel that this should ever happen.

I have a POW that went up to Martinsburg. He has a service-connected condition and was a POW for 14 months. He was treated very rudely and was not given any treatment whatsoever at Martinsburg, WV.

I also have a paralyzed veteran in Dumfries for whom I applied for vehicle allowance and prosthesis allowance and lift in July 1980. A certificate of eligibility for this equipment was approved in January. That means that he was restricted to his home for that length of time, and we still don't have the equipment in the van.

Mr. Chairman, I said all the above to say this. The doctors and nurses and all of the veterans' organizations are concerned with having enough funds to carry out the responsibility that is contained within title 38.

Another thing, Mr. Chairman—it has been known in the VA system for some time now about phantom beds and missing nurses and doctors. The House Veterans' Affairs Committee visited 16 of these facilities and found 20 percent of the beds that were listed, were not available for admissions because of the short funds in the budget.

Mr. Chairman, I have a list of names which I will not include in my testimony, but which have already been furnished to your staff, which will bear out what I am telling you as truth. I have contacted all of these people and your staff can contact them. In some cases, I do not have phone numbers because the people cannot afford a phone.

I appreciate the privilege of appearing before your committee to give testimony on this, Mr. Chairman. Thank you.

[The combined prepared statements of Mr. O'Toole, Mr. Simmons, and Mr. Newsome appear on p. 129.]

Chairman CRANSTON. Thank you very much for that very helpful testimony. What you said gives us added cause for very great concern.

Until I indicated otherwise, the questions I am going to put to you are for each of you. Would you each give a brief response because of our time constraints?

At the VAMC, with which you are most familiar, how far in advance are various clinic appointments booked up? Let's start with Mr. Woodworth.

Mr. WOODWORTH. 60 days. That is just to be seen, not treated, Mr. Chairman.

Chairman CRANSTON. Larry?

Mr. DAWSON. A lot of cases are running up to 5 months, and that is combining all three medical facilities.

Chairman CRANSTON. Jerry?

Mr. COX. Specialty clinics, 60 to 90 days.

Chairman CRANSTON. Alfred?

Mr. SIMMONS. Specialty clinics, about 90 days.

Chairman CRANSTON. Robert?

Mr. Newsome. It would depend on which facility, Mr. Chairman, but it is running 60 to 90 days.

Chairman Cranston. Thank you all, and thanks for the very brief answers.

In your experience, where are VA eligible veterans going when they are turned away by VA or who are given clinic appointments many months in the future? What do they do as alternatives?

Mr. Woodworth. It is very appropriate that you ask that question, Mr. Chairman. I have had a lot of veterans in that situation recently.

Most veterans are using Medicare. Any service-connected disabled veteran who is really disabled is using Medicare instead of the VA health care system, at a greater cost to the taxpayers than the VA health care system.

Chairman Cranston. To be eligible, don't they have to be totally incapacitated?

Mr. Woodworth. Yes they do, sir.

Chairman Cranston. So there are people being turned away or having to wait a long time who are totally incapacitated?

Mr. Woodworth. Yes, they are, even service-connected category A veterans are opting to use Medicare instead of the VA health care system because of the wait.

Chairman Cranston. Is that because they are afraid they are never going to get attention?

Mr. Woodworth. It is because they just cannot wait.

Chairman Cranston. Thank you.

Larry?

Mr. Dawson. In Arizona, there were three hospitals that opened up what they call a MedVet Program, where they would accept the Medicare payment from Social Security as opposed to the veteran having to put anything out of pocket. So we had a large exodus from the hospital over to three MedVet facilities. Other than that, a lot who are military retired are trying to get back to the military hospitals, which is overburdening their load.

A lot of them go to county hospitals, too—any place where they can get the free care and get it now. A lot of them have stated that they do not mind waiting that 12 to 14 hours in line to be treated as long as they get the treatment.

Chairman Cranston. Jerry?

Mr. Cox. No treatment at all, in many cases. Our psychiatric patients are becoming the homeless on the streets.

Chairman Cranston. Alfred?

Mr. Simmons. In most cases, the ones who can qualify for Medicaid are going to Medicaid. I think the vast majority will not have any treatment, or they would opt to not get the treatment because they just cannot afford it. Those who are over the age of 65 or otherwise qualify for Medicare will go to the Medicare system.

Chairman Cranston. Robert?

Mr. Newsome. Mr. Chairman, in plain simple English, they suffer, because they do not have the funds at their disposal to get the treatment any place else. A lot of my people are coal miners or farmers and they do not have Medicare, so they just plain suffer.

Mr. Woodworth. Mr. Chairman, if I may make an additional comment?

Chairman CRANSTON. Please.

Mr. WOODWORTH. I do not want to give the committee the idea that a lot of veterans are leaving the system and that we are reducing the work level. We are not. We had an additional 89,000 veterans come into the system over last year's services at Memphis, so it is not a reduction in care.

Chairman CRANSTON. Let me now ask each of you this question: what do you say to a veteran under these circumstances? What do you tell a category B or C veteran who asks what his chances are of getting inpatient care from the VA or being seen at a VA outpatient clinic?

Mr. WOODWORTH. I have to tell him what his entitlement is under the VA regulations and, after that, I explain to him why it is done this way, because of the means test, and basically, I have to tell him and then take the brunt of his anger that he is not eligible. He cannot get his care and has to go elsewhere.

Chairman CRANSTON. Larry?

Mr. DAWSON. Basically, it is the same thing. We tell them what the law provides for and try to find other agencies that will help them in the community. That is about the only thing we can do.

Chairman CRANSTON. In effect, you are saying, "The law provides the following, but we can't comply with the law?"

Mr. DAWSON. You can refer them to the medical facility and let them go ahead and make application, go through the means testing——

Chairman CRANSTON. But they do not get the treatment that they are supposedly entitled to by law?

Mr. DAWSON. No, they are not getting the treatment.

Chairman CRANSTON. Jerry?

Mr. COX. Depending on the situation, I have picked up the phone and called a friend at the hospital, someone I have worked well with in the past, asked as a favor if they would look at this gentleman again, and sent the man back out to the hospital.

Chairman CRANSTON. Alfred?

Mr. SIMMONS. I think all of us as service officers probably do about the same thing, as far as first of all, trying to get the veteran care in the VA facility. If that does not pan out, then you look for an alternative health care provider system.

The hard thing that we all suffer from day to day is, "If I am supposed to have it, why doesn't the Government have it available and provide it to me?" That is the hard question that you have to answer.

Chairman CRANSTON. Robert?

Mr. DAWSON. Mr. Chairman, it is just like you said. They authorize the treatment and the facilities do not have the funds to administer treatment. I just keep going from VA hospital to VA hospital until sooner or later, I get my veteran served. But that is not on a timely manner. He suffers until this happens.

Chairman CRANSTON. Let me start on this end this time and go back the other way.

From your observation, what has been the impact of the budget shortfall on the quality of care and on staff morale at the VA facilities that you deal with?

Mr. **Newsome**. The impact on it has been tremendous. I cannot fault the VA hospitals because they have to pull their operations within the funds that they have to operate the hospital. There has been a tremendous impact on the veterans' treatment.

Chairman **Cranston**. Alfred.

Mr. **Simmons**. Within the past couple of months, the covers of the magazines of two of the largest veterans' organizations, The American Legion and the VFW that I represent probably tells the story of the impact more than I could do here in the very short time we have. The cover of the VFW magazine has, "Phantom Beds and Missing Nurses." That is the impact of shortfalls of——

Chairman **Cranston**. I really am not asking about that. I am asking about what has happened to the quality of care and what has happened to the morale of the people at the facilities.

Mr. **Simmons**. The morale of the health care providers is very low in all three medical centers in Maryland that I have talked with. The morale is low.

Chairman **Cranston**. What has happened to the quality of care?

Mr. **Simmons**. The quality of care is not what it ought to be. It is less than adequate, from the standpoint that we are seeing too many patients with too few staff people.

Chairman **Cranston**. Has the quality declined within the past year?

Mr. **Simmons**. Yes sir, I would say that it has.

Chairman **Cranston**. Let me go on to Jerry now.

Mr. **Cox**. Morale is low among VA employees. They are an outstanding group of individuals, the doctors, nurses, and management staff, but they are stretched to the extreme in their work loads with nursing shortages and doctor shortages.

Veterans become depressed because they have to wait such a long period of time for examinations or to be seen.

Chairman **Cranston**. Larry?

Mr. **Dawson**. Looking at the three hospitals we have, the morale is probably at an all-time low. The people on staff try their utmost to do what they can in the prescribed period, but you can see the strain.

The phone conversations you have on cases get considerably shorter. The amount of time that they have to research something for you or to cooperate with you is diminished greatly. It is extremely sad in some situations, but they do not have the time even to deal with you and help you out.

Chairman **Cranston**. Richard?

Mr. **Woodworth**. Mr. Chairman, the VA has the capability of providing the best quality medical care in the United States, regardless of which system you want to compare it to in the private sector. Yet, we have veterans who have ilio-conduit surgery down in the Jackson DVA Hospital, who should never have their care given there to begin with.

We have spinal cord injury centers that specialize in spinal cord injured veterans. We had a particular veteran who went down there, had an ilio-conduit surgery, returned to the clinic a week later to have his stitches removed, went home to have his stomach rip open. He and his wife had to put his intestines back into his stomach and get him to a private hospital, where he underwent surgery and was again returned to the same hospital where he should have never been admitted in the first place.

Why this happens, I do not know. There are regulations that specifically prohibit it, but it continues to happen. I can only say that I think it is due to lack of funding.

Chairman **Cranston**. Would you provide us more details on that case for the record?

Mr. **Woodworth**. Yes, sir. The veteran's name is Billy Kraft. He is a service-connected quadriplegic veteran who is rated for the maximum level for aid and attendance that is allowable under the law.

Chairman **Cranston**. If you would give us the additional material for the record, I would appreciate it.

Mr. **Woodworth**. Yes sir, I will.

[The information furnished is retained in the committee files.]

Chairman **Cranston**. Senator Jeffords, do you have any questions?

Senator **Jeffords**. Yes, Mr. Chairman.

Mr. Simmons, you indicated that the average age of veterans of World War II is now 69. That would indicate to me that the peak is not yet here as to demands of World War II veterans, so I ask this of all of you.

Do you have any projections given to you or of your own judgments as to what the situation will be when that peak arrives, say 5 years from now, as to the capacity of your facilities to meet the health care needs of veterans? Is the situation going to get worse, much worse?

Mr. **Simmons**. It is going to be worse as the veterans get older, and the peak will be at about age 74, the average lifespan at this time.

In Maryland, we are getting a new hospital that will accommodate more inpatients. That is what is happening in Maryland, but across the board, I think that the budget shortfalls are going to make it more difficult to get into VA medical centers.

Senator **Jeffords**. Any others, please?

Mr. **Dawson**. To give you an example, Senator Jeffords, we are looking at two nursing home care facilities that are due to be constructed and or ready to open. If those facilities were open today, we could fill them with qualified veterans and have that many more on the waiting list.

This is going to continue to get worse. There is no way that we can construct to keep up with the demand under the current budget restraints.

Mr. **Woodworth**. Senator Jeffords, with current restraints of funding, we do not have to wait 5 years to see what the impact is going to be. In a matter of 2 years time, I would say that we will have to close down the VA Health Care System, because we will not be able to provide quality medical care, and if you cannot provide quality medical care, we would be opening ourselves up to litigation. There would be no need for a VA Health Care System if we cannot adequately fund it.

Senator **Jeffords**. Anyone else?

Mr. **Newsome**. I do not believe that we can ever afford to close down the VA hospital system. I think that this point is a crisis stage and every year is going to get worse without the proper funding to take care of our veterans. I do not think we can ever consider closing the VA hospital centers.

Senator JEFFORDS. Information has come to my attention that 30 percent of the male homeless are veterans. From your experience, does that seem to be an accurate number?

Mr. NEWSOME. I think it is greater than that. My figures show it to be greater than 30 percent.

Senator JEFFORDS. Anyone else want to comment on that?

Mr. DAWSON. I think we had a rough count of 9,000 homeless in the city of Phoenix last year. The VA did some research, and I would say that the estimate of 30 percent is rather low. We are looking at a figure upwards of 50 percent who were veterans.

Senator JEFFORDS. Thank you, Mr. Chairman.

Chairman CRANSTON. Thank you very much.

What cuts at the VA facilities you deal with have been the most harmful, in your view, in terms of the needs of sick and disabled veterans? Which particular cuts have done the most damage?

Mr. NEWSOME. I think that altogether, the cuts in the medical care facilities has been the greatest, Mr. Chairman. They all have been terrible, as far as I am concerned, but I think the cuts in the medical care facilities has had the greatest impact.

Chairman CRANSTON. Alfred.

Mr. SIMMONS. I am certain that in my area, it is inpatient medical care.

Chairman CRANSTON. Would you stress which programs within the medical care where the cuts have hurt the most?

Mr. SIMMONS. Inpatient hospitalization of those category A veterans, those veterans who should have inpatient medical care on demand, who because of the priority system, must seek medical care somewhere else. When there are no beds in the hospital to take care of a patient who, by law, should be able to be taken care of, and that patient has to go somewhere else to seek medical care—that has been the problem that I deal with most often and that is most frustrating.

Chairman CRANSTON. You are saying that some category A people who are entitled, not just eligible for but entitled to certain care, are not getting it.

Mr. SIMMONS. Because of the priority system—within category A, there are certain levels of priority. Therefore, they are low enough on the priority that if there are no beds, there are no beds. The system needs to be expanded to be able to accommodate all veterans who should have care on demand. The system does not take care of them now.

Chairman CRANSTON. Jerry?

Mr. COX. The veterans that come into our office with complaints or problems seem to always circle back to the lack of staffing. When the person has an orthopedic disability or needs an eye exam—things of this nature—when he has to wait 3 months for this specialty clinic, it is very upsetting to him.

For instance, if he needs a new leg built or things of this nature, he goes to see the physician in the outpatient clinic first, and then the physician there certifies him over to the specialty clinic to be seen for the fitting of a new prosthesis, which will be 90 days down-the road. It seems that it always circles right back to staffing, whether it is nursing or lack of doctors.

Chairman CRANSTON. Larry.

Mr. DAWSON. I would have to concur with Jerry on the staffing problem. We are looking at some critical areas. When a hospital cannot even get qualified physical therapists, occupational therapists, pharmaceutical staff— right now, as a prime example, an entry level therapist at the VA comes in at around $27,000 per year. They can walk out on the streets of Phoenix and go into a pool at $65,000 per year. There is no way that the VA can continue to compete.

Needless to say, the quality of care suffers, in that they do not have the staff to devote to each patient that is needed. More often than not, if you walk in for a clinic appointment, a doctor has you down for about 2 minutes and it takes him about 3 minutes to write down his notations on the visit and the prescriptions, and then you are on your way.

Most veterans walk away from that totally frustrated. I could not even tell him what was wrong—he did not allow me that opportunity.

Chairman CRANSTON. Richard.

Mr. WOODWORTH. I agree with my colleagues in part, but I differ in that I feel that pharmaceutical supplies and prosthetics are the two major areas where funding is really hurting veterans. We have pharmaceutical delays as much as 30 days in some of the medical centers in the Memphis area.

If a veteran goes without medication for 30 days, he is going to have to be in the hospital. Again, that just causes more budget shortfalls. In prosthetics, you have basically the same experience happening.

Chairman CRANSTON. I have been very concerned about the prosthetic backlog. If we had time, I would ask some questions this morning, but I will submit some in writing for the record. That completes the questions that I have for you all. I will have written questions for the record for all of you.

Senator JEFFORDS. Mr. Chairman, may I ask one additional question?

Chairman CRANSTON. Certainly.

Senator JEFFORDS. Do you believe that the medical center directors should have the ability to manage their own resources and make decisions on what programs to cut, or do you believe that would be better coming with a central decision made for all hospitals to do the same with respect to these kinds of discretionary decisions?

Mr. WOODWORTH. I feel that the medical center director is probably the most knowledgeable within the VA as far as what his medical center needs and how those funds should be used. He has to transfer funds when necessary to the other departments, and he has to do it where it is going to affect the veteran the least. I think he is the best person to manage those funds.

Senator JEFFORDS. Jerry.

Mr. COX. I feel that the director should be responsible. It is hard for an employee sitting here in Washington to determine just what a hospital actually needs in one of the small communities, such as

Lebanon, PA or Marlin, TX. I would say that it should be the directors.

Mr. **SIMMONS**. I believe the director should be able to manage his resources. In our area, we are not being impacted as much as the Florida area, especially the aging veterans, and there is no reason to think that we can expect a central office here in Washington to make a blanket decision that will affect all medical centers equally. So, the director on site is the one who would be best able to decide how his resources ought to be used.

Mr. **NEWSOME**. I would take an exception to that. In most cases, it would depend on who your hospital director is, but I like the new Secretary's statement that before any service is discontinued at a VA medical center, he is to be notified. I like that statement. Overall, I guess what they are saying is true, but it depends on the hospital director.

Mr. **WOODWORTH**. Senator Jeffords, if I may?

Senator **JEFFORDS**. Yes.

Mr. **WOODWORTH**. A prime example of how we are kind of using money foolishly is that, in Memphis, we have to send the patients laundry, pajamas, linens, and the like, to Little Rock to be cleaned and returned to Memphis. We have the facilities right in Memphis to do it.

We had to spend an additional $250,000 this year for patient pajamas because they were lost in being sent to Little Rock, and we already have the facilities to do it, but they cannot be used. That decision was made through VA Central Office.

Mr. **DAWSON**. I basically have the same feeling. More often than not, the director of that hospital knows that if he has a ceiling of 300 nurses on staff, but his needs is for maybe a physical therapist, he could cut one position or downgrade a position to accommodate his needs. He may not need as much money in construction as opposed to actual equipment, such as CAT scanners, cardiovascular equipment, and such, that they may need immediately to provide care to veterans in life and death situations.

Instead, he has the money tied up over here in some future construction project, so yes, I do believe that the directors should have the authority to control their funds. I qualify that by saying, without loss of benefit entitlements to veterans, naturally.

Senator **JEFFORDS**. Thank you, Mr. Chairman.

Chairman **CRANSTON**. Thank you.

I want to thank The American Legion, the Veterans of Foreign Wars, and the Vietnam Veterans of America for very helpful testimony and materials that were submitted for the record today at our oversight hearing in addition to your verbal comments. The Legion and VFW information derives from their very helpful field visitations to VA medical centers around the country, the reports of which are routinely shared with us.

As I indicated, we will have written questions for the record for each of you. Thank you all very much for your testimony.

Chairman **CRANSTON**. I now call the second panel, consisting of VA Field Officials, three Directors of VA Medical Centers, two Chiefs of Staff, two Directors of Social Work Services, and one Head Nurse. These are the people who are working very hard to keep the VA health care system going in these very difficult, fiscally restricting times. We appreciate the VA's cooperation in making these witnesses available for this hearing and the witnesses willingness to share their perspective on the effects on veterans of the budget shortfall.

We have three VA Medical Center Directors, Gary DeGasta, the Director of the VAMC in White River Junction, VT; Tom Holthaus, Director of the VAMC in Togus, ME; and Tom Mullon, the Director of the VAMC in Minneapolis, MN. We have two VA Chiefs of Staff, Dr. Jacqueline Parthemore, Chief of Staff of the VAMC in San Diego, and Dr. Sam Threefoot, Chief of Staff of the VAMC in New Orleans.

I want to give a special California welcome to you, Dr. Parthemore. I know you have been at the San Diego VAMC throughout your entire, very distinguished 17-year VA career. It is noteworthy that you believe that Chiefs of Staff should not be tied to their desks, so you also remain an attending physician on the medical ward and direct an endocrinology clinic. I think that is great.

We have two Chiefs of Social Work, Steve Petty, from the Jerry Pettis Memorial Hospital in Loma Linda, CA—another California welcome to you—and Anne Pope, from the VAMC in Hines, IL.

I welcome you, Steve. Your compassion and commitment to veterans and innovative ways of helping them are well known throughout California and the VA system as a whole. You have been a prime mover in setting up many novel and imaginative programs to expand the reach of VA programs, including programs to provide veterans with health care at home. I am proud of what you two Californians have accomplished.

Finally and very importantly, we have Head Nurse Thresa Wilson, from the VAMC in St. Louis, MO. Ms. Wilson heads up a surgical ward of 40 beds.

Having welcomed each of you, I now ask you to rise and raise your right hand to be sworn in.

[Witnesses sworn.]

Chairman CRANSTON. Mr. DeGasta, I know that Senator Jeffords is keenly interested in your testimony this morning.

Did you want to say any word, Senator Jeffords?

Senator JEFFORDS. I just want to welcome Gary here. He has recently come to our medical center in White River Junction, which has a reputation as being one of the finest in the country, and he has had to make some very difficult decisions recently because of budget shortfalls. I am very pleased that he is here to be able to relate to us the very hard decisions that are being required of our hospitals at this time.

Gary, it is good to have you with us.

Chairman CRANSTON. I know that Senator Mitchell would be welcoming you, Mr. Holthaus, if he were not overwhelmed with leadership duties. I know that he will be reviewing the testimony that you give today.

We did not ask any of you to provide prepared statements. Instead, you have been asked to be here today to respond to questions, with which we will now proceed. Generally, my questions will be directed to each of you unless I indicate otherwise.

I again want to express my thanks to each of you for traveling so far to be with us. We much appreciate the vital work that all of you are doing.

I am going to ask a series of targeted questions to which I would like you to respond briefly, as the previous panel did. At the conclusion of this panel, I will have a more general question about the funding and resources at your facilities.

To begin, would you each please tell the committee the number of years of professional experience that you have had with the VA, and generally, where you served?

Let's start with you, Gary.

TESTIMONY OF GARY DeGASTA, DIRECTOR, VA MEDICAL CENTER, WHITE RIVER JUNCTION, VT

Mr. DeGasta. I have 21 years with the Veterans' Administration—leaving the military in 1967, I joined the VA as a social worker in Albany, NY in 1968. I moved from Albany to White River Junction, where I served as the Chief Social Worker. I went from there to Boston, where I trained as an Associate Director. I served as an Associate Director in Kerrville, TX, West Roxbury, MA and Cincinnati, OH. I moved from Cincinnati to Washington, DC, to serve as Deputy Regional Director, Southwestern Region, VA Central Office. I returned to White River Junction as the Director about 1½ years ago.

TESTIMONY OF TOM HOLTHAUS, DIRECTOR, VA MEDICAL CENTER, TOGUS, ME

Mr. Holthaus. I began my career with the Veterans' Administration in 1966 after I graduated from the University of Minnesota, after completing 3 years in the military. Since 1966, I served in Medical Administration, at Fargo, ND; Ft. Meade, SD; Lexington, KY; Saginaw, MI; Tacoma, WA; and Associate Director at Butler, PA; Marion, IN; Little Rock, AR; San Juan, PR; and now I am Director at Togus, ME.

Chairman Cranston. Thank you.

Dr. Parthemore?

TESTIMONY OF DR. JACQUELINE PARTHEMORE, CHIEF OF STAFF, VA MEDICAL CENTER, SAN DIEGO, CA

Dr. Parthemore. I have been with the VA since 1972 and I have been at the San Diego Veterans Medical Center for that entire time. I entered there following my fellowship in endocrinology. I have been a Research Associate of the VA, the Assistant Chief of Medical Service, and the Chief of Staff.

Chairman Cranston. Sam?

TESTIMONY OF DR. SAM THREEFOOT, CHIEF OF STAFF, VA MEDICAL CENTER, NEW ORLEANS, LA

Dr. Threefoot. I began with the VA in 1970 as Chief of Staff from the Forest Hill Division in Augusta, GA. I returned to New Orleans, from where I had come in 1976, and I have been there ever since. Before I entered the VA, I had been Director of Research and Medical Education at Touro Infirmary, a private hospital in New Orleans affiliated with Tulane University, at which I was and am a Professor of Medicine.

Chairman CRANSTON. Thank you.

Anne?

TESTIMONY OF ANNE POPE, DIRECTOR OF SOCIAL WORK, VA MEDICAL CENTER, HINES, IL

Ms. POPE. I have been with the VA 22 years. I started out with the VA in the Chicago area. However, I must say that I was a student as well in the VA and trained in Indianapolis. My clinical social work experience carried me from Chicago Lakeside to Jackson, MS, back to Chicago at Lakeside, and then to Hines VA, where I became a supervisor. I trained as a Chief Social Worker in Buffalo, NY, went to New Orleans, and I am now back at Hines VAMC.

Chairman CRANSTON. Steve?

TESTIMONY OF STEVE PETTY, DIRECTOR OF SOCIAL WORK SERVICES, JERRY PETTIS MEMORIAL VETERANS HOSPITAL, LOMA LINDA, CA

Mr. PETTY. I am Steve Petty, and I have been with the Veterans' Administration 22 years also. I started as a social work trainee in Salt Lake City and took my first regular professional assignment at Palo Alto VA Hospital. I was there in psychiatry for 7½ years.

I transferred to help open the Audie Murphy Hospital as a Medical Social Worker Supervisor, and was there for just 13 months. I returned to California to Brentwood, now West Los Angeles as the Assistant Chief of Social Work Service, and I have been at Loma Linda for the past 11 years.

TESTIMONY OF TOM MULLON, DIRECTOR, VA MEDICAL CENTER, MINNEAPOLIS, MN

Mr. MULLON. I began my VA career about 25 years ago at Montrose, NY, and then moved to Manchester, NH, to Palo Alto, CA, to Martinez, CA, to Tacoma, WA, to East Orange, NJ, to Manhattan, NY. From Manhattan to Fort Wayne, IN, to St. Cloud, MN, to San Francisco, CA, to Omaha, NE, and now I am in Minneapolis. I have served in a variety of different positions throughout that career.

Chairman CRANSTON. I would like to have your frequent flyer miles. [Laughter.]

Thresa?

TESTIMONY OF THRESA WILSON, HEAD NURSE, VA MEDICAL CENTER, ST. LOUIS, MO

Ms. WILSON. I really feel like the novice on this panel. I have been with the VA 8 years. I joined in October, 1981, after 4 years in the Air Force Nurse Corps. I spent 1 year as a staff nurse and have spent the past 7 years as Head Nurse of a 40-bed, multiservice surgical ward at St. Louis VA Medical Center.

Chairman CRANSTON. Thank you all very much. You have obviously had wide, varied, and very significant experience and background in light of what we are trying to learn today in the course of this hearing.

Now, I would like to ask if you would each please compare the situation at your facility today to the situation a year ago and 2 years ago, with particular emphasis on inpatient census, outpatient visits, staffing levels, and staff morale. Again, try to do that very concisely because of our time constraints this morning.

Mr. DeGasta. I have been in my institution for about 1½ years. When I arrived at White River Junction I was facing a $1.7 million recurring deficit.

I have significantly reduced staffing in our institution—we currently have 89 fewer people now than when I first got there. I eliminated three programs—Hospital-Based Home Care, our Nursing Home Care unit, which is a 30-bed unit, and a 16-bed Alcohol Rehabilitation unit.

I might add that recently, I have been able to reopen two of those programs, Hospital-Based Home Care program, and the nursing care unit. My alcohol program remains closed.

We have also decreased our inpatient census. I am running, as of yesterday, 100 patients in the institution. That is about 17 to 20 fewer patients than I had last year at this time and about 10 or 15 below where our census was 2 years before that.

Our outpatient work load is slightly less than it was last year. We are having some significant financial impacts on our institution. My concern is that, if indeed, our money situation does not improve, we will have to make some additional adaptations in our program.

Chairman Cranston. Tom?

Mr. Holthaus. Mr. Chairman, the past fiscal year, our employment level was at about 970, and even though we completed the fiscal year at that level, we did not have the adequate moneys to support that ceiling and we had to divert approximately $700,000 worth of equipment moneys, nonrecurring maintenance moneys, and others to maintain that ceiling. Then, when we went into fiscal year 1989, we realized we were going to have another shortfall to the tune of approximately $1.5 million.

At that point, to preserve the quality of care as best we could, we felt it best to make vertical cuts instead of horizontal cuts. At that time, we closed a medical unit, an acute psychiatry unit; decreased our drug dependency unit in half; and closed an outpatient clinic in Portland. Even with those things, we find ourselves with a budget shortfall again this year. I am keeping equipment dollars and nonrecurring maintenance project dollars in reserve because I may need those to get through the fiscal year.

Our work load, as far as outpatient work load, has increased drastically. In fact, 4 years ago we had approximately 50,000 outpatient visits. This past year, it was in excess of 90,000 outpatient visits.

Of course our inpatient census, with the reductions we have taken, has gone down. I think that will continue to happen. Let me give you an example of what happened when we initially closed some of the units regarding diminished referral sources.

When we initially had the resources or the available beds, and a veteran appeared at a private facility—for example, a psychiatric patient—the physician would contact us, we would have a bed available, and we would accept that patient. However once we closed the unit, after two or three telephone calls from our referring sources, with us telling them, "I am sorry; we don't have an available bed,"—we are now no longer receiving those calls.

I think the staff morale—we are trying certainly to maintain the morale the best we can. However, I think we have been asking our people to work at 110 percent and we are very thankful for the work ethic in Maine. We can ask people to work at 110 percent productivity, but I do not think you can ask people to do that for very long. I am afraid that we will end up with significantly decreased morale.

Chairman CRANSTON. Jackie?

Dr. PARTHEMORE. We began fiscal year 1988 projecting a $4 million deficit, which we had to make up for; and we began fiscal year 1989 projecting a $7 million deficit in funding to be able to provide ongoing services. We have lost 170 FTE since 1986. We have closed 30 medical/surgical beds, 15 medicine, 15 surgery last year, in order to assist us in our deficit. We have closed 30 nursing home care unit beds this year in order to assist us in our deficit.

We obviously make every effort that we can to postpone equipment purchases, as that money can then be used to provide patient care. We had a total equipment request for fiscal year 1988 in the under-$100,000 category of $1.8 million and we funded $800,000. We have an equipment request for replacement and additional in the under-$100,000 category for fiscal year 1989 of $800,000 and our funds available for fiscal year 1989 are $285,000.

We have ongoing problems with the increasing cost of patients with AIDS in our area. We have diminished the length of time that we place patients on nursing home contracts in order to be able to utilize those funds for patient care.

Yes, we have a morale problem. Physicians, nurses, all of the staff, are having a great deal of difficulty in coping with issues that are related to what amounts to the rationing of patient care.

Chairman CRANSTON. Thank you very much.

Sam?

Dr. THREEFOOT. The figures I will give must be taken in the context of the situation in Louisiana, which is the depressed economy of an oil-dependent State, currently the highest unemployment rate in the Nation, with the loss of health insurance by those workers, and marked decreases in services provided by the State hospital system.

Consequently, in spite of our efforts to reduce our work load, there has been a significant increase in both the number of inpatients and outpatients that we have been seeing. In the first 4 months of fiscal year 1989, the number of inpatients treated increased by 404 over the same period in 1988. If that same trend continues it projects to an increase of approximately 1,200 patients for the year.

As far as outpatients—from October through February, the first 5 months of fiscal year 1989—the number of unique patients seen increased by 496 over the same period in 1988. The number of visits has increased during that 5 month period by 3,800.

Simultaneously, there has been a decrease in our budget. While the budget increased actually by $1.2 million, this was not able to support but 1,504 FTEEs, compared to 1,544 last year. That is a decrease in 40 FTEE this current year.

We have calculated that we would have a $1.7 million shortfall, which cannot exist, so it must be made up by decreases in services provided in such things as cleaning, needed repairs, et cetera. Last year, we converted $378,000 from equipment to take care of patients and $375,000 in nonrecurring maintenance to take care of patients, a total of approximately $750,000.

This year, the equipment money is fixed, fenced in, so we will not convert any equipment money this year. However, we must make up our projected shortfall in other ways.

Chairman Cranston. Thank you very much.

Anne?

Ms. Pope. I will not attempt to address the issues overall in terms of dollars and patient census. I think our situation would be very comparable to that which has been given by the directors.

I would like to focus on some other areas and talk about the fact that, at Hines in particular, we have seen a decrease in our inpatient load (ADC), but we have also seen a higher turnover rate. In particular, since the B and C categories came into being, we have begun to see a decrease in female veterans coming because they tend to be in higher income categories.

We have not discontinued programs for A, but some for B and C; e.g. respite. Patients who are in B or C categories are not admitted for nonacute care, not because they do not qualify as veterans, but for reasons of income and decreased resources. We have seen problems in terms of recruiting people, too. Last fiscal year in particular, in my service alone, I was down seven positions. We were frozen in effect. That was a pattern that was being practiced throughout the hospital due to inadequate funding.

When you cannot hire staff, be it for reasons of money, or an inability to locate qualified staff, and we do have our problems in those areas and others—it is a real problem in rendering services. Even if you have fewer patients (census) and, we in social work have noticed a significant increase in patients seen, they tend to have greater problems. The needs are very significant and great.

We have also encountered a decrease in some of our programs, particularly in terms of substance abuse programs. We have had a decrease in dollars for our community-based programs for substance abuse. When funds were cut in half in fiscal year 1987 and subsequently received late in fiscal year 1988, some of the community agencies had closed. So we are boxed in, in the house, and also boxed in, in the community because of limited and lack of resources with high demand.

Chairman Cranston. Steve?

Mr. Petty. Loma Linda is into its fifth consecutive year of serious budgetary shortfalls. Since 1984 we have seen our outpatient work load grow from 158,000 to 195,000. We have witnessed the establishment of a POW program that has grown to be the largest in the VA system, with over 650 active cases of former POWs. We have activated an additional 60-bed nursing home care program, and at the same time, our number of yearend employees has increased by only six, from 1,302 to 1,308.

In each of the past 3 years, we have made significant diversions of equipment replacement moneys to cover daily operation expenses. This has resulted in equipment that has 12 years of wear and tear on it and that is 15 years obsolete.

We have had significant staffing cuts in some areas and lengthy recruiting delays. We have discontinued all services to 1,800 B and C category patients and we have stopped providing over the counter drugs.

In spite of these efforts, our hospital is currently projecting a $1.5 million budget deficit unless additional funding becomes available for this year or unless still further services are eliminated. This, coupled with the noncompetitive salary schedule, has put morale at an all time low. We are losing our best and brightest to outside health care organizations, thus further decreasing the quality of care we are capable of providing.

Chairman CRANSTON. Tom?

Mr. MULLON. At Minneapolis, I guess I could describe our atmosphere as one of frustration—frustration among veterans, among staff, among management, and among the members and the dean of the medical school. One of the reasons for that is that in June 1988, we moved from an older facility into a brand new hospital in Minneapolis, a beautiful facility completed about $80 million under budget and about 4 months ahead of schedule, which is rather unusual in the Federal Government.

However, this beautiful facility is only partially utilized as a result of the cuts we had to experience in fiscal year 1989. We had to reduce $6.8 million from our budget for 1989 and we had to reduce our staff by 104 people.

We have waiting lists in surgery, which are now at 782. We have long delays in our outpatient clinics, running from 3 to 6 months in delays, and we have veterans who are rightly proud of their hospital, but cannot get any care delivered in that hospital or cannot get the kind of care that they expected to receive when that hospital was built. So in one sense, Mr. Chairman, we have used resources very well in the Federal Government, but then have not provided adequate funding to operate and activate those resources.

Just to give you an example, we have a 120-bed nursing home care unit with only 40 beds operational at this point. Of our 725 acute-care beds, medical and surgical, 110 of those beds are not operational at this point. Yet we have a 30 percent increase in the applications for care at our medical center. All of this adds up to a great deal of frustration and a hope that perhaps there will be some help this year which will continue into fiscal year 1990.

Chairman CRANSTON. Thank you.

Thresa?

Ms. WILSON. I cannot attest to numbers, but as I said earlier, I work on a 40-bed surgical unit. I have four generic services of my own.

Routinely, I would have five surgeries per day. In the past 2 years, I may have had anywhere from 7 to 15 surgeries per day and anywhere from 4 to 18 admissions per day, which accounts for a large turnover of patients. I also may have 10 discharges per day.

I am doing this with a routine staff of three nurses, most days two, myself being the second nurse, as the Head Nurse, with five people. That makes it very hard to give the veterans the care they are used to when they come to the VA.

Morale is very low at my facility right now. Generally we go through periods of shortages, but you could always see the light at the end of the tunnel. This year, we don't see the light at the end of the tunnel, and we have not even reached our peak shortage time, which is the summer.

We have positions that are open, where they are attempting to recruit, but when the hospital down the way is offering $5,000 bonuses and you are not even sure what your salary is going to be when you come to the VA, because of the way the system is set up, it means that we are going to have a hard time competing.

Once we get the employee, we have a hard time retaining the employee because of our work load. The people that have left my facility do not leave so much because of the benefits and money they finally get. They leave because of our work load. There are very few places in the private sector where a nurse is responsible for 40 patients with three other people or where, on a day tour, including the head nurse, responsible for 20 patients. And we are not talking about patients who are up and about. The acuity level of the patients has increased over the years that I have been in the VA.

I have a 16-bed ward. When I first started with the VA, 15 of those patients would be up and about. Now I am no longer in that situation, so I feel like it is a real morale problem. I really do believe that the quality of patient care is in jeopardy.

Chairman CRANSTON. What about the staff, other than RNs? Have there been cuts there, too?

Ms. WILSON. Yes sir, and that affects the nursing staff. We are not just talking RNs when we talk nursing. We are also talking about supportive staff, such as LPNs, nursing assistants, and also the ancillary staff, such as respiratory therapists, physical therapists, social workers, and the whole gamut. That all impacts on nursing—even the clerical support. Without the clerical support in place, the nurse generally has to pick up those duties, because the patient does not stop needing things because everybody goes home at 4:30 p.m.

Chairman CRANSTON. Senator Jeffords?

Senator JEFFORDS. Thank you, Mr. Chairman. I will try to figure out a way to shorten down the answers.

The previous panel indicated that they anticipated a larger demand for the future because of our aging population of veterans. Is there anyone that disagrees with that, and if so, would you raise your hand?

[No response.]

Senator JEFFORDS. All right. May the record show that no one disagrees.

Second, and this part is more important to me in the sense of where we are going to go in the future. Have you received from the Veterans' Administration any projections on what your increase in future demand will be? Has anybody received such a document indicating that? If so, raise your hand.

[No response.]

Senator JEFFORDS. All right. The answer to that is, no.

Have you, with all the other demands that have been placed upon you, had an opportunity yourselves to be able to take a look at such information as may be available to indicate what your future demand is going to be by virtue of the aging population?

Dr. **THREEFOOT**. The planning boards for each district and for each region do make projections of work load. I do not have those figures here, but they are available. However, there is some uncertainty because they are just what they say, projections. I think it remains to be seen.

Several years ago there was a study made of what effects the aging population would have on the work load of the VA and that data is available. I am sure that someone could give the reference to that. I can't, but some of those studies have been done.

Senator **JEFFORDS**. Jacqueline?

Dr. **PARTHEMORE**. Most of the projections are also based on historical data, and I have great concerns that, as health care insurance increases and as the cost of health care goes up, that there would be the potential for a greater number of veteran patients to choose to use the services of the VA if we had them available.

Mr. **HOLTHAUS**. Senator, we have done projections through the medical district as far as what type of facility we need in Maine and have certainly found that we need increased nursing home care unit beds and intermediate care beds. In fact, we have submitted a proposal to increase our nursing home care beds from the current level of 60 to 100.

Mr. **DEGASTA**. Senator, clearly you know the closing of our NHC unit and the problems that caused us. We certainly know that there is a need for long-term care for our veterans. That need is expected to continue to increase.

Senator **JEFFORDS**. Thank you.

Mr. Mullon indicated that they were having a 30-percent increase in demand at this time. Who among you are experiencing an increasing demand at this time? Would you raise your hands?

[Show of hands.]

Senator **JEFFORDS**. All right. I think that most everyone is experiencing an increase in demand.

Could you very briefly give us a percentage of increase in demand at present, rough as it may be?

Mr. **DEGASTA**. While they are digging out the materials, let me comment if I may, Senator?

Senator **JEFFORDS**. Please.

Mr. **DEGASTA**. I think that issue of demand can sometimes be misrepresented. In Vermont, when we started closing down specific programs, some of our veterans got the impression we really were not going to any longer provide them medical care and services. Some no longer attempt to access the system as readily as they would have in the past. Clearly, we are finding that to be the case in Vermont. A number of our veterans have not even attempted to come back to us because of the actions we have had to take.

Senator **JEFFORDS**. That was my next question, but it is good to combine them.

Dr. **PARTHEMORE**. I was going to comment on that, too.

Senator **JEFFORDS**. Please do.

Dr. **Parthemore**. We had been experiencing growth in the demand for patient services until we took the recent step of informing category B and C patients that we could no longer provide outpatient services for them. Since that time—and we stopped providing them around the first of January—we found that our discharges are now down about 10 to 15 percent and our outpatient work load has fallen about 5 percent. We had an increasing work load to a peak of about 220,000 outpatient visits in fiscal year 1988.

Senator **Jeffords**. Any other comments?

Dr. **Threefoot**. I presented some of those figures of increased demand in New Orleans when I presented my statement.

Senator **Jeffords**. Yes.

Ms. **Pope**. Our experience is one of having perhaps a decrease for category A patient care, but I think it is related to the fact that we sent out letters stating that the eligibility was changing for categories B and C based on income and need for acute care. I think we had a net impact of scaring people away. As far as our clinics are concerned, we still have a great demand for clinic visits and at the same time, we are having to make those appointments significantly in advance.

Mr. **Mullon**. Senator, when I mentioned 30 percent in the increase of demand earlier, that is true, but I will tell you this: as we continue to ratchet down the system, more and more people become frustrated, and we are going to see less and less satisfaction and more and more moving to other sources of care, away from us.

Mr. **Petty**. The increase in demand at Loma Linda has been significant and steady. For example, between fiscal years 1987 and 1988, our outpatient work load increased from 175,685 to 194,676. Our demand for inpatient services has increased steadily over the years, too. It was up almost 400 between 1986 and 1987. We did have a decrease of about 1,000 admissions between 1987 and 1988, but I do not believe that was due to decrease in demand or need for care. I believe it had to do with other factors, like not being able to recruit nurses and having to close wards.

Senator **Jeffords**. The earlier panel agreed that you on the administrative end need more discretion. Is there anyone here that would like to have less discretion in how to handle your budgets?

[No response.]

Senator **Jeffords**. Let the record show that no one wants to have less discretion. I presume then, that you all believe you should have more. Is there anyone that disagrees with that?

[No response.]

Senator **Jeffords**. All right, thank you.

The last one is a very perplexing question to me. We recently received information from the Veterans' Administration that 25 percent of the individuals who received outpatient care from the VA fall into the following categories: nonveteran, nonapplicable, or unknown. From your experience, is that a valid statistic? Is there anyone that believes it is a valid statistic?

[No response.]

Senator **Jeffords**. May the record show that no one is indicating that it is a valid statistic from their own information.

Would anyone make some comments on that statistic?

Mr. **Mullon**. Senator, you know that included in outpatient visits are personnel health visits. That is included in the count, and many of our employees are nonveterans, yet they would be counted as an outpatient visit for personnel health purposes. There may be some distortion there. If you get to the exact veteran count, I do not think you will find that percentage applies.

Dr. **Parthemore**. I also asked my MAS people why my numbers were the way they were, and I was informed that, pending means test completion, patients are placed in the nonveteran category. That explained why we appeared to have somewhat higher numbers.

Mr. **DeGasta**. Up until recently, Senator, there was not a great push to resolve issues of the so-called "undecided veterans." Now with the category B and category C differentiation, it is imperative that we make the differentiation to ensure that we are assigning the proper eligibility categories to our veterans. As a result, we have taken a different stance in MAS in recent months.

Dr. **Threefoot**. I have some data from the New Orleans hospital that was prepared on March 29, last week. Thirty-two and a half percent of our inpatient work load fell into category A, service connected; 63 percent into category A, nonservice connected; 2 percent into category B; 0.79 percent into category C; and 0.02 percent, 0.04 percent, and 0.05 percent into some of the other unknown categories. Those were inpatients with a very small percentage that were not category A. The category A group was about 97 percent.

Mr. **Petty**. There is a nonveteran category that I think needs to be brought up because it is an extremely important work load. That has to do with family members of seriously debilitated veterans who are being cared for at home. In terms of primary contacts with VA staff, it is the family members who are trying to care for a bed-ridden, tube-fed, seriously debilitated veteran. Those visits are often logged as nonveterans.

Dr. **Parthemore**. Particularly, the psychiatric patients. Family therapy is part of psychiatric patient care.

Mr. **Mullon**. Research patients, also. It is possible that some of those patients that would have been seen would have been research patients, which would have been nonveterans. We do take nonveterans into research projects.

Senator **Jeffords**. I appreciate that information because this is an awfully dangerous statistic. I can just see that one being thrown out and used to say, "Hey, we can cut things back 25 percent just by getting rid of the nonveteran population."

Dr. **Threefoot**. On outpatients, the total number of category A is essentially the same, 98 percent, but it is interesting to note that in New Orleans, the service-connected category A group is about 35 percent in the outpatients, whereas in our Baton Rouge clinic, service connected is 58 percent. We do not know why that occurs, but I thought it was very interesting. That increases our total percentage of service connected if you combine the two.

Senator **Jeffords**. One last question. The homeless statistic that I mentioned before indicated that there is a large number of veterans in the homeless population. What kind of programs do you have or what involvement do you have with helping the homeless? I would like to get some examples of that to get an idea what is going on with respect to the administrative end of the VA in servicing homeless people.

Mr. **Mullon**. In Minneapolis we have found that about 1 in 4 in the homeless population are veterans, based on studies conducted by our social workers. We set up a program with the VA Medical Center in St. Cloud and also with the Golden Plump Poultry producers in St. Cloud, where veterans who are found among the homeless on the streets can be referred to our St. Cloud hospital and they are assisted there until they are ready, physically or mentally, to move into employment. Then, with an arrangement with this private company, we are able to send veterans to work in this company for a period of 3 months to determine whether or not they can satisfactorily adjust to a work environment.

This had worked out extremely well. We have had no fallouts in this program from the business that we deal with. We are quite proud of the kind of community/VA relationship that we have established here, and we have helped a lot of veterans by doing this.

Senator **Jeffords**. Anyone else want to comment?

Ms. **Pope**. We have a homeless program at our hospital and we have it as a part of the homeless chronically Mentally Ill Project. We have been going into the community, into shelters, and really working with other community agencies to identify homeless veterans.

We bring them into the hospital to have them evaluated, treated, and then placed in these residential treatment facilities. We think that we have been fairly successful in that we have been able to return about 60 percent of those that we have located back into the community either in gainful employment or at least reunited with family members.

Senator **Jeffords**. Sam?

Dr. **Threefoot**. We have the homeless, chronically mentally ill program, and between July, 1987 and February 1, 1989, approximately 750 homeless veterans were screened. Of these, 535 received treatment and of those, 289 or 54 percent of all those veterans receiving treatment have been successfully returned to independent living.

Mr. **Petty**. As I stated earlier, Loma Linda has had severe financial difficulties for a number of years, and in response to that we have taken a rather aggressive and creative approach in trying to expand whatever resources were available through the VA by looking outside for areas to augment that. Our homeless program is a good example of that.

We applied for VA funding when it was available through competition, and because there was not enough money for homelessness to go around, we were turned down. So we worked through a collaborative project with a nonprofit corporation in California called Bridges and have since been able to establish a 14-bed social, vocational, restoration and job placement facility for homeless veterans, and what is unique about it is the funding sources.

That includes the VA, which provided us with $45,000 in nonrecurring funds for the first year. The Labor Department provided $70,000 through the Stuart B. McKinney Homeless Assistance Act. We also picked up funding from Vietnam Veterans of America, the

Military Order of the Purple Heart, the Vietnam Veterans 'Aid Foundation, a Teamsters Local, and the local United Way.

Senator JEFFORDS. Thank you.

Tom?

Mr. HOLTHAUS. Senator, we routinely visit shelters throughout the State. Maine does not have as high a percentage of homeless veterans as other parts of the country, but we still go out and seek out the homeless veteran. If they need hospital care, they will be referred to the facility or if they need help with any benefits, we will help them out with that.

Senator JEFFORDS. Gary?

Mr. DEGASTA. As you know, Senator, Vermont a rural State with no formal VA program for outreach to the homeless. Our two Vietnam Veterans' Outreach Centers, one in Burlington and the other in White River Junction, have been focal points for some activities.

Clearly there is a need for homeless services. Just because we are in a rural area does not mean that we have no homeless veterans. The homeless are a little less obvious or visible in a rural area than they would be in a metropolitan area, but homelessness is a problem for our State as well.

Dr. PARTHEMORE. May I comment on something?

Senator JEFFORDS. Certainly.

Dr. PARTHEMORE. We participate in a chronically mentally ill homeless program. Studies in our area have shown that many of the homeless are Vietnam era veterans, and we had hopes of being able to provide outreach services since this group of veterans has traditionally shunned the hospitals, but now is entering the age group when they are developing heart disease, diabetes, and other of the diseases of aging.

We had plans to attempt to outreach these groups and to go where they were, both to the vet centers and to the downtown shelters. However, we have had to table those plans because of our funding situation.

Senator JEFFORDS. Thank you, Mr. Chairman.

Chairman CRANSTON. Thank you very much.

I am stuck with other commitments this morning—I know that Senator Jeffords must also leave. Mr. Steinberg is going to take over to ask the questions that I would ask if I were here.

I do want to ask Dr. Gronvall to come forward at this point, and I want to say that I appreciate very much your agreeing to be with us today to hear the field testimony and then to answer questions at the end of the hearing. As I have indicated, I have to leave to go elsewhere, so I would like to now administer the oath to you before I leave as I have done with the others.

[Witness sworn.]

Chairman CRANSTON. As I indicated, Jon Steinberg will be carrying on in my absence.

I want to thank you, Dr. Gronvall, and Secretary Derwinski, for your cooperation in expediting the response which we received as requested yesterday evening to my April 3 letter. We greatly appreciate getting that response so promptly.

Dr. GRONVALL. Thank you, sir.

Chairman CRANSTON. I am now going to ask another question of the whole panel, while Dr. Gronvall sits with us, and I will probably leave before it has gone very far across the table, unfortunately.

Let me recognize Senator Cohen before I leave for any opening statement.

If you are going to be able to stay here, please preside for awhile as I have to leave very shortly. We will keep going anyway with Jon Steinberg presiding in my absence.

Senator COHEN. Thank you, Mr. Chairman.

Chairman CRANSTON. What has been the greatest difficulty that you face at your facility in dealing with the reduced funding levels?

We will start with you, Gary.

Mr. DEGASTA. I think that it clearly is the impact that reduced funding has had on service to our veterans. To see an institution like the one I have been associated with now for 1½ years, an institution with a proud history of 50 years of service, with staff that is demoralized as a result of turning away veterans because they are ineligible—it is a very disheartening thing for me, and clearly, a very frustrating experience for our staff as well.

Chairman CRANSTON. Since Mr. Holthaus is next, why don't you come with your questions, Senator Cohen?

Senator COHEN. What is your timeframe, Mr. Chairman?

Chairman CRANSTON. I must leave in 5 minutes, but it doesn't matter because Jon Steinberg will take over.

Senator COHEN. Thank you very much for allowing me to participate in this hearing today.

I would like to get parochial and just address a couple of questions to Tom Holthaus, who has been really instrumental in rebuilding morale at the VA Hospital at Togus. He really is held in the highest esteem by Maine veterans across the board. I want to publicly commend you for the job you have done, Tom. Unfortunately, in recent months you have been forced to make some significant reductions. I assume that the other witnesses will probably say the same thing.

You closed a medical/surgical ward, closed a psychiatric ward, closed half your inpatient alcohol and drug rehabilitation unit, and you are closing an outpatient drug treatment unit.

What is going to be the impact of these closings on your ability to compete for funding under the VA's resource allocation system? Have you got a catch 22 system in which, on the one hand, you are forced by inadequate funding to shut all these programs down, only to find that then funding is cut back further under the resource allocation system?

Mr. HOLTHAUS. Very much so. We are in a catch 22 situation. However, to survive and to provide the quality of care, last year and this year we found no choice but to make those drastic cuts. Yes, the number of veterans that we are treating is going down and will continue to go down as long as we have those units closed. Our discharges are going to go down and the number of patients treated under the RAM methodology—I think we are definitely going to suffer.

Senator COHEN. Even assuming that we were to come up with a $303 million supplemental appropriation as opposed to the $618 million recommended by this committee, is that going to be sufficient for you to put back on line the wards you have been closing down?

Mr. HOLTHAUS. In order to maintain our core program, you know we lost, our shortfall was basically $1.5 million, and even if we received the $1.5 million at Togus, it might be questionable whether we could even put on line all of those programs that we cut. We've got other serious problems, such as staffing. We've got a lot of serious problems with equipment. We've been in a situation for 2 years, not replacing much of our needed equipment. In fact, right now I've got a list of replacement equipment that is absolutely essential to be replaced to the tune of $750,000.

If we were to be fully funded again, or the $1.5 million brought back, I would have to really take a good look to see if we could put all the things back on line.

Senator COHEN. Another question, if I could, deals with rural hospital funds being parochial if I can. I have served on the Select Committee on Aging since 1974, I served on the House Committee on Aging, and find myself rapidly approaching that category.

We filed a report that indicated that we have unique problems in rural areas such as the State of Maine. Rural residents, including veterans, for example, tend to be poor, they tend not to have insurance, they tend not to partake in the many programs that are available in urban areas, and so they have unique circumstances where the people, the veterans, who live in the rural areas tend to be more dependent upon VA services than veterans living in urban areas.

Is that a situation that you find in a State like Maine?

Mr. HOLTHAUS. That is correct, Senator, absolutely.

Senator COHEN. Now, unfortunately, you cannot take advantage—we also found in this report you can't take advantage of certain economies of scale, by virtue of the fact that we are so rural and so isolated. One has a long distance to travel in order to get to Togus from many parts of Maine.

This puts you once again right into a conflict with the RAM, doesn't it?

Mr. HOLTHAUS. It's very difficult for us to compete with other programs. For example, to provide the basic mission, we have a basic surgical, medicine, and psychiatry unit. Our closest VA facility is in Boston, 170 miles away. In order for us to perform and have surgery, in a 25-bed unit, you have to have the basics, you have to have the orthopedic surgeon, the chest surgeon, the general surgeons. And at some point with our fixed costs, we cannot compete. I just don't see how we compete with somebody in a much larger facility.

Senator COHEN. In fiscal year 1989, the VA categorized hospitals into six groups, and you now compete for funds with those hospitals in the group to which you have been assigned. Now, apparently Togus is grouped with both rural and urban hospitals including North Chicago, Columbus, outpatient clinics in Boston and Los Angeles.

Do you think this division into the six groups has succeeded in putting similarly situated hospitals in the same group, or has it increased the unfairness of the allocation system?

Mr. HOLTHAUS. It's pretty hard to say with the resource allocation model. I believe the resource allocation model can be utilized and could be a good management tool, but I tend to find a system where, in order to have a winner, if we may call it that, for someone to receive funds, additional funding, one of your partners, one of your partner hospitals must be a loser. And I don't think in a health care system that is all necessarily fair, and I also don't believe you can have a resource allocation model that does not have enough money in the overall budget to begin with. So we're using decreasing dollars to divide among all our medical centers, and in order to be a winner, you have to have a loser.

Senator COHEN. A general question I'll just throw out to all of you. Do you think factors such as quality of care and equity of access should be taken into account in the RAM as opposed to simply the efficiency standard that has been used by the VA to measure your qualification for funds.

Let me just shift from you, Tom, and ask the others.

Are those factors that ought to be taken into account?

Dr. THREEFOOT. The difficulty in using quality of care to determine distribution of funds is one how to judge quality of care. Some medical facilities see patients who are much more complex than others, so that morbidity or mortality rates may not be an adequate gauge to use.

Also, if you have a medical facility in which the quality of care, if there were a standard to use, were judged to be less than some other facility, they may need more money, not less, in order to bring that quality up to those standards.

I think the questions asked of the service organizations when they were here, gave the impression that the quality of care had decreased.

I am not sure that the quality of care rendered any individual patient at a medical facility is decreasing. However, the number of patients, or the number of procedures, the kinds of things we are able to do, may be decreasing. The postponement of putting in a hip prosthesis, because you have to ration the number of prostheses you can buy in a quarter, affects the quality of life of that patient, but once we get to it, the quality of the surgery is just as good.

So I think that those are pretty hard things to gauge if you're talking about the distribution of resources on that basis.

Senator COHEN. What about equity of access?

Dr. PARTHEMORE. As someone who comes from an area that has a very high cost of living, even equity of access becomes a difficult question, because the dollars available to someone for health care are less when the cost of living is higher. And I am not sure how you handle some of those issues.

I presume that patients turn to us in our area because their costs are high, that they need psychiatric care, which often isn't covered by insurance, or other kinds of high cost care, or they have entered a phase of their illness that is a very high-cost phase of the illness, such as drugs, chemotherapy, or surgery, and so they chose to turn to the VA in the past.

I find it a difficult problem.

Ms. Wilson. I think, while we're talking about quality care, I think the issue today is to provide safe care. We have standards for quality of care. We have JCAHO standards that we must meet in order to stay certified, whatever the word is for it, but right now at my facility, we're up for a visit soon. We just got the standards. I look at the standards, and I cringe, because with my staffing the way it is now, you know, the hope for meeting those are slim.

So, we have to address not just the number of patients getting to the VA and the number of patients being seen, but what they're getting once they get there, because of the shortage of staffing. They are not getting what they were getting when I came to the VA in 1981. And I see that to continue, because the patient has changed, the patient in my area is sicker.

Mr. DeGasta. Sir, may I make a comment? White River Junction, VT is a sister rural facility to your fair State. We are affiliated with the Dartmouth Medical School, which is a fine medical school. We have similar problems as Tom does, in Maine.

We have had to, because of the rural nature of our State, be the primary provider, the only medical provider, for a number of our veterans for many years. Now, because we have categorized those veterans differently, we are denying them access to care. I have sent 1,500 letters to veterans telling them they are no longer eligible for care based on VA eligibility criterion. We're cutting them off at the front door in our case. That's how we are able to cope. That's what we have to do. I don't like it, but that's our charge.

There are problems of access, there are problems of limiting workload.

Dr. Parthemore. I think all of these are kinds of approaches of how to deal with what most of us perceive as inadequate funding in total; and then how to redistribute, as I think Mr. Holthaus was suggesting, not enough dollars to cover the system.

Senator Cohen. What you are saying is that, when we cut the funding, then that sends everybody scurrying to find ways in which they are going to meet their budgets, and you end up with some of the artificial, perhaps, classifications or mechanisms to try and spread the dollars as effectively as you can. And if you increase the funding that will relieve most of the pressure.

Are we still going to be faced with the current RAMs and not take into account the kind of problems that we have in Maine or Vermont in terms of travel distance, in terms of poverty. I think what I gather is those from the urban areas say, "Look, we've got problems here, we have a higher cost of living than you do in Maine."

I might dispute that, by the way, but in terms of——

Dr. Parthemore. And we have more AIDS patients.

Senator Cohen. More AIDS patients, that's right.

Dr. Parthemore. I think each of the hospitals copes with different kinds of problems.

Mr. DeGasta. One thing for sure, though, Senator, we all have problems. I have done the same thing as Tom has done. I'm sure Tom Mullon has done the same thing as well. I have purchased almost no medical equipment in the past 2 years. I've done almost no construction whatever in my facility for nearly 2 years. My fear is that unless something happens, unless we take care of our buildings, unless we replace our equipment, unless we take care of our staff, we are going to have our staff deserting us in droves and we are not going to be able to provide the quality care which some of us feel that we have been able to provide up until recently.

Mr. HOLTHAUS. Our staff is getting—they're getting frustrated, Senator. I visit the floors on Togus's nursing units on a daily basis. And the patients that they are taking care of today are much different than the patients they were taking care of even 5 or 6 years ago.

Senator COHEN. What's different today, Tom?

Mr. HOLTHAUS. They are sicker. They need much, much more direct care from the nursing personnel.

Senator COHEN. They are older?

Mr. HOLTHAUS. They are older. They have more complicated problems, and the length of stay is shorter. They are coming in, they are staying less time. And we're still doing with the same amount of nursing personnel. Also we don't have the proper support personnel, the ward clerks not on duty in the evening, and pharmacy, housekeeping, and engineering support. And again, if those folks aren't there, the nurses have to pick that up, and when I hear comments from nurses at the end of the day, with the head nurse, they work 8 hours and they never even had time to discuss much of what was going on during the day with any of their other employees, because they, themselves were so busy taking care of patients. I don't know how long we can hold onto those folks.

Senator COHEN. I don't know whether it is true of the other hospitals, but for a number of years Vietnam veterans were not seeking treatment at the Togus VA hospital. There was some resistance and resentment toward the bureaucracy and toward the power structure, as such. And lately, at least in Maine, the experience has been they have been coming in to become part of the system.

Now, I assume that that has probably been true in other States as well, presenting different types of problems, in terms of drug addiction or alcoholism or psychiatric problems that still remain.

Is that the case, Tom?

Ms. POPE. That is indeed the case at our hospital, which has been impacted further by the fact that we had to close one of our wards (substance abuse), and what we are finding, is that patients are coming in early in the morning, essentially lining up, trying to compete for the availability of beds. And, of course, they become very angry, they become very frustrated, and I think basically we begin to feel that we are sitting on a can of worms that just might explode at any moment.

Many of these people also are in a dual diagnosis category, they are very difficult in terms of attempting to place in resources in the community. People don't want to deal with them. They also present problems in the hospital, and those problems are magnified further when you don't have the adequate staff to try and engage them in treatment processes, and just basically as a way of maintaining.

So I think that, in effect, we are all really in a kind of catch 22. We are juggling multiple kinds of things there, attempting to deal with the shortfalls in terms of the fiscal realities.

As an additional factor of frustration, as Mr. Mullon has identified, we used to be comfortable in dealing with the qualified veteran who said, "I want to come into the VA." Previously, as the clinician, and now as an administrator I would be very comfortable in saying, "Oh, yes, just make sure you're honorably discharged, present yourself at Admitting, and be evaluated."

There's another variable now, and that variable really has to do with income. The kinds of issues that we're having to deal with, in person also by phone, no matter how great we are and how professional we are, after you have engaged in multiple expressions of hostility, by the end of the day, you have also been really very worn down; it comes from multiple sources.

Mr. **Mullon**. Senator, in the urban environment, and we've heard from the rural environment, and I work within that environment, and the problems are intense and they are difficult. In the urban environment, as in the rural environment, we are competing for personnel. This is very really important because the private health care system is in the same problem status as we are, as you know, I am sure.

And when you are competing with personnel, you have got to be able to present the kind of an image of a hospital that delivers good care and provides things for your people. Otherwise, a spiral begins, and you begin to lose people and you can't recruit people. And they go to other hospitals, and before you know it, you've got the kind of frustration and the kind of burnout that these people are trying to describe to you today. And this goes on in our wards, it goes on in the rural hospital wards. Once the funding starts to dry up, you begin this downward spiral, and you have to reverse that. If you don't reverse it this year, and next year you are going to end up with a system that has no people of any quality working within it.

I am not kidding about this. This is serious business. If you want a health care system, you have got to provide the funds to recruit the good people, to keep people, so you don't lose them to the private health care system.

That's where our frustration is.

Senator **Cohen**. I notice from the front page of the Washington Post today that the administration is now going to consider some 25 percent salary increase of certain executive level officials. It seemed to me that the same rationale applies in almost geometric proportions to what is going on in the VA hospitals. They are getting concerned we are going to lose good people, be they judges or executive branch members at NIH, or wherever they may be because we've not paying them enough. That they are going to go up in the private sector, and you are going to have a demoralizing spin into mediocrity or worse.

Dr. **Parthemore**. I think another concern also is that, as dollars constrict, a variety of areas are looked at in terms of where savings could be made. I know that I have a great concern that dollars for training positions also are being constricted, because they represent entry level jobs in many respects for us, be they psychology or social worker trainees or house staff trainees. And we utilize those people to supplement an already shrunken work force. So that, in every way, things are being impacted for us well beyond the very obvious areas.

Senator **Cohen**. Well, I am going to cease and desist. This is an unusual situation. I am not a member of this committee. I have already been given more time than all the committees I serve on legitimately. So I hope to turn the committee back to the staff. I was stalling for perhaps one of the other members to come in, but I see it is not going to take place. But thank you very much for allowing me to come, and thank you for your answers.

Mr. **Steinberg**. It is our pleasure to have had you here, Senator Cohen, and you are like the 800-pound gorilla, you can sit anywhere you want and you can ask questions as long as you wish. [Laughter.]

Senator **Cohen**. Thank you.

Mr. **Steinberg**. Let me pick up where Senator Cranston was in his third question. But before I do, let me again express his regrets that the scheduling change interfered with what we had planned to be about a 3-hour hearing, and we are sorry that this has occurred and hope that the inconvenience of our moving forward has not been too much of an imposition on any of you.

I might also say, Dr. Gronvall, we are delighted to have you with us and we are delighted to have you sitting where you are sitting, but we will not be getting to you for a bit more. You are welcome to either remain there or, if you would be more comfortable, not, whichever you choose.

Returning to the question that Senator Cranston had asked, starting on the right side, and I believe that Gary had already answered it, and I think that Tom has already covered it pretty well in his responses. So we will start with Jacqueline.

What has been the biggest difficulty you have faced at your facility in San Diego in dealing with the reduced funding levels?

Dr. **Parthemore**. That is such a generic question, because it affects everything we do. And, from my standpoint as the Chief of Staff, in talking to my staff I try to make it very clear to them that they participate in helping us decide what it is we will do and how we will get to where we have to get with the dollars that we do have. But when it comes to an individual patient, they must deal only with what they think is best for that individual patient, and let me worry about the dollars, or if necessary, let the director worry about the dollars.

But I constantly am concerned in the back of my mind that financial issues may intrude on areas of judgment which should be solely in the best interest of the individual patient that is being confronted.

As a small example, for instance, while here in Washington I talked with my office and was told that they were making arrangements for a patient to have a relatively inexpensive test done at the university. It's a test that we usually do, it's a test that we have the equipment for, and the equipment is not old equipment. But apparently we needed a $240 replacement part, and engineering service doesn't have the money in its budget at the present time, or didn't think it did, to get the replacement part.

And so we then have to make arrangements for the patient to be transferred to have the test done, which is a preoperative test.

It's those sorts of little things that we know, even though it doesn't always come to our attention, have to be going on and have to be affecting the way we do business. And I think it affects everybody who comes to us or is working there. At times when we don't have papers and pencils, that tells people something about the institution that they work in.

Mr. **Steinberg**. Were you suggesting—and we had a later question on this—but were you suggesting that your concern is about quality of care?

Dr. **Parthemore**. Always when you have to be concerned about enough dollars to go around, you worry about whether or not issues exit related to quality; whether or not quality could be compromised over issues of dollars.

Mr. **Steinberg**. We'll sort of convert this question as we go, then, from rather than talking about the biggest difficulty that you think you are facing at your facility under the reduced funding levels, to either answer that question, if you think you can, and maybe it's a difficult one, or to followup on the point that Jackie raised about quality of care, and whether you share those concerns.

Sam?

Dr. **Threefoot**. I think all of these are interrelated. And what I can do is to state some of the problems that the budget shortfall is presenting to us.

We have a 10-bed surgical stepdown unit that has been ready to occupy since last March, but we have had difficulty in recruiting critical care nurses. We have not been able to recruit enough to staff our ongoing units of MICU, CCU, and SICU, and therefore, have used pool nurses at a great expense, and are not able to open the stepdown unit. This has an impact.

I think that the decreasing FTEE that we are able to support, as Thresa had mentioned, it's not just RNs or physicians, but the support personnel, and I think Mr. Mullon covered this awhile ago, that if you don't have couriers or escort personnel and the nurses have to take a patient down to x ray, they get demoralized in a hurry. They're not taking care of a patient on the ward. That makes recruiting more difficult. We cannot compete salary-wise. When we do compete with the benefits that the VA offers, we lose when nonnursing duties must be performed by nurses. It's very demoralizing and they suffer burnout.

Other difficulties that we have are with pharmacy. We have high-expense pharmacy items for the large number of AIDS patients that we have. We rank number 15 in the latest tabulation of numbers of AIDS patients. We have 47 patients on AZT at the present time. We have quite a few patients on cyclosporin. We do not do transplants, but these patients were ours, had transplants elsewhere, and must be on cyclosporin to prevent rejection, and that's a very expensive item.

That's just two examples, but I have quite a few others that I could give.

Mr. **Steinberg**. Let me move to Anne and see if you want to share with us either your concerns about quality of care or your concerns about the greatest difficulty that you are facing either at the hospital or just in social work, generally, in terms of the funding shortfall.

Ms. **Pope**. I think that I have all the concerns that have been identified here because we are very much a part of that. We get a lot of the fallout. Even though we are an ancillary support service, if nursing is having a problem and the physicians are having problems, social work certainly has a problem.

Being discharge planners in particular, families see us as trying to help them to alleviate and eliminate many problems that they are encountering. We're seeing an increasing number of people coming, and my staff, as I am sure other social work staffs, are having the problem of trying to understand and effectively deal with what's going on really at this particular point in time and continually help.

The feeling is one of attempting to overcome that the VA has turned its back on the people who serve this country. That is an overriding theme. And we're having to try and make sense out of that, as we are relating to the very constituents that we are trying to serve.

Now, that perhaps is a philosophical approach, but it is one that we have to deal with. I think that people are, my staff as well as others, are becoming very discouraged with the system because it has gone back on its word. People are beginning to feel that we are now welfare people who are having to determine eligibility. I think they are struggling with everything they have got in terms of trying to deal with the information we need to give.

We are seeing people (veterans) in the VA using tactics often used to qualify for public aid. An example is the recent case of a couple divorcing after 40 years of marriage in order to qualify for medical care. The veteran has a chronic illness. I think that is a pretty big issue with which we are confronted, and we are struggling to understand why!

Mr. **Steinberg**. Steve?

Mr. **Petty**. Very clearly, the most difficult issue to live with is that 1,800 letters we sent out to category B and C veterans, explaining to them that we could no longer provide care to them. Social work service, as Ms. Pope indicated, is kind of at the end of the line when the Veterans' Administration doesn't know what else to do with the veteran. They are instructed to go to social work service so that we can help them find alternatives to VA care. And sometimes there just isn't any. And these are real people we are dealing with, and if you would, I would like to just give you a very brief synopsis of just one case that I think will tell you the kind of situations we are running into.

This patient happens to be a 58-year-old female veteran, and I mention both of those facts because of the VA's recent emphasis on attempting to address issues of female veterans. And at age 58 is not eligible for one of the main alternatives to VA care, and that is Medicare, she's too young.

The VA has treated Mrs. X for the last 6 years, including 10 hospitalizations, 97 outpatient appointments. Her diagnoses have included unstable angina, left breast cancer, right breast mass, bilateral mastectomy and breast reconstructions, breast cancer with bone metastasis. Mrs. X was last hospitalized January 16 for confusion, with depression and hallucinations. Mental health staff saw her and determined her mental status was due to the normal grieving process from having been told that she was going to die, complicated by chemotherapy and radiation therapy. With supportive psychotherapy and medication adjustments, she improved and was discharged on January 19. On February 1, she was mailed a letter informing her that, in essence, "due to budgetary limitations," the VA can no longer afford to provide care for her because her husband gets $1,600 a month, and urged her to "arrange continuation of your medical care in the community."

Now, as I said, Mrs. X is too young for Medicare. She has no alternative health care insurance, and is now uninsurable because of her terminal condition. $1,600 a month might be considered a middle level income in certain parts of the country and allow private pay medical care, but not in Southern California, where the average home in our neighborhood costs $150,000, and the average apartment rents for $600.

I've got some other cases I could tell you that are similar to this one.

Mr. STEINBERG. We'd be glad to have you provide additional examples like that for the record, if you would wish to.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

Another case example involves a veteran in his midfifties who is a chronic schizophrenic who had been provided psychiatric treatment by the VA for 9 years. The veteran had been living with his retarded brother in the family home, both of them being cared for by their mother. However, the mother died. Shortly thereafter, the veteran and his brother were found living in absolute filth and squaller, totally unable to care and provide for their own needs. A conservator was appointed for both the veteran and his brother under the California Lanham Petri Short Act. The brother was placed in a home for the developmentally disabled and the veteran was placed into the VA's Board and Care Home Program. The conservator then sold the family home. The veteran's share of the proceeds from the family home gave him assets in excess of the limits to category A, therefore, making him ineligible for continuation of VA care. This is a veteran who becomes so anxious and upset at any kind of change that the annual review for conservatorship leads to an acute psychotic episode and hospitalization. How he is being asked to relate to entire new mental health system through the county. A system that is also overloaded.

The next case example involves an 84-year-old female veteran with stage 3 tongue cancer who is dependent on liquid nourishments. Because of our cutbacks in nonprescription pharmaceuticals, we no longer supply her with the Isocal that was her main nourishment. The Isocal, at VA expense, costs $78 per month because of our bulk purchasing capabilities. The cost to the patient at the local pharmacy was $171 per month. This veteran's total income is $425 per month and at the moment she is attempting to survive on Carnation Instant Breakfast.

The third case involves a 100 percent service-connected spinal cord injured quadriplegic. This patient reports being in constant pain. Our Rehabilitation Medicine Service ran tests with the new electronic nerve stimulators and the veteran reported substantial relief. However, he has been required to wait several months to purchase one of these due to a shortage in prosthetic funding.

Mr. STEINBERG. Tom?

Mr. MULLON. I would also like to cite some examples from my hospital on the same subject. That is a very, very difficult matter to deal with.

We had over 3,500 letters we sent out to category B and C veterans that had to be discontinued for care, and we received many letters in return, and perhaps the Senators in our State have received more than we have about that issue. It's a difficult problem, and access is one of our most trying situations right now. In our dealing with veterans in these issues, I have only admiration and support for our social workers, I don't know how they do it.

On the quality issue, now that's one that I am very concerned about. I mentioned earlier in my testimony that we have 780 people on waiting lists now for surgery. These are elective surgery cases.

Mr. STEINBERG. As compared to how many a year ago, for example?

Mr. MULLON. A year ago we probably had, I don't know the exact number, but around 250 to 300, a significant increase.

Mr. STEINBERG. A tripling.

Mr. MULLON. Yes.

How do you measure the quality of services for those people? If we had the prosthetic items, if we had the money for the prosthetic items and the orthopedic items that we could purchase to be used in our surgery, we could bring many of those patients in the hospital and treat them, and provide the service for them, but we don't have enough money in our budget to provide orthopedic items that many of these veterans need.

Now, how can you say that those people are not receiving quality care? Well, they are not receiving any care. And, under those circumstances, all you can say is that we hope that somewhere they are going to receive it, perhaps, or they are not going to receive any care.

When they do come in our hospitals—I think this is true in all the hospitals represented here today—we try to provide them the very, very highest quality. It is a matter of how many people can you take care of, and when the quantity starts to rise, you have got to ration, and that's the situation. And when you ration people out of the system you are going to very soon find that those people are going to be in more serious problems later on, and they are going to come back as an acute care episode within the hospital and have to be seen and treated with a more resource-intensive level of care.

The thing to do, I think, is to take care of them now, use the resources now and prevent that acute episode in the future that's going to cost you more money.

So quality, yes, we think we do give good care in the VA, but to the people who don't receive the care, how will you measure that quality and are you going to provide service for them in the future? Those are the questions that still remain to be answered when we talk about budget shortfall.

Mr. STEINBERG. Thresa?

Ms. WILSON. I think a lot of the—the biggest impact I see is on staffing. You know, the numbers that were originally allocated to the VA back when I first came, they were already meager. But now you are expected to do more with less. The patients, to me, are sicker and, I deal with them every day. I have patients who tell me two days later they had chest pain because they didn't want to bother me because I was so busy. You know, that kind of thing shouldn't happen. But it happens.

You have a patient who comes in, needs a piece of equipment. You have to borrow it from another patient to use it on a patient that needs it now.

I can remember running down three flights of stairs to find a box of Kleenex for a patient having a nosebleed, and that was like a month ago.

You know, these are things that we are periodically out of, running upstairs looking for nasal cannulas for someone who is gasping for breath on your ward. Fortunately they don't happen every day. But one time is plenty. And, the time I take running, looking for things, I'm taken away from patient care. And, you know, we haven't even talked about patient teaching, preventive teaching, and preventive care. Those things right now are laid to the side so you can take care of the day-to-day physical needs of the patients.

We are no longer meeting the psychological needs of the patients.

The veteran patient, when he comes in, is very needy. You know, he likes the staff to spend time with him. We haven't been able to do that lately. The families are used to being able to call and be able to talk about what's going on with their loved one, but, you get down to a choice between prioritizing whether you spend 20 minutes on the phone talking to the family member or 20 minutes down the hall giving direct care.

So I truly believe the quality of care has been affected. It may not be that severe in all cases, but there is no way you can decrease the numbers of people taking care of the patients and not affect the quality of care.

Mr. **Steinberg**. I am going to yield in one moment to Senator Murkowski's representative, the Minority Staff Director, Al Ptak. But just in order to keep the continuity of questions for one moment, since we sort of shifted to quality of care when Jackie spoke, I thought I would give Gary and Tom an opportunity to speak to that issue briefly, and then, Al, we will yield to you.

Mr. **DeGasta**. Thank you, Mr. Steinberg.

I would like to make a comment. I believe the statements made by my colleagues are quite true. When a veteran is in our facility, he still receives good quality care. However, when I look at the waiting times for a hip replacement, as Sam talked about, 3 months or 4 months for a veteran who has to have a hip prosthesis—and I cannot permit the surgery to be done because I don't have the dollars to let our capable surgeons do that work—I don't think that is good quality care. I don't think that waiting times up to 200 days for a clinic appointment because I have no openings or I do not have the staff to care for those patients, I don't think that is good quality care.

When our patients receive health care it is high quality care, comparable to the private sector. But deferring care, I don't like that.

I also don't like having a physician substitute a financial judgment for a clinical judgment. I believe we should not force our clinical staff to defer care of a patient because of their concern that is going to cost too much money. I don't think that is quality care.

These are the kinds of issues that scare me.

Mr. **Steinberg**. Tom?

Mr. **Holthaus**. We also provide very high quality care once we have the patient in our hospital. But I want to just touch on one area which I think definitely will affect quality of care, and that is replacement of equipment. I want to give you a specific example at Togus.

For example, we have an x ray machine that's over 12 years old which has been due for replacement for several years. The replacement cost is about $220,000, installation another $80,000. Now, this equipment has failed on many occasions, necessitating moving a patient who is having a barium enema performed to another room.

Now, this is very, very stressful, not only on the patient but the radiologist and the technologist. To me, I would question whether this is the high type of quality that we want to provide.

Mr. **STEINBERG**. Al, we now yield to you.

Mr. **PTAK**. Thanks very much, Jon.

Senator Murkowski is very sorry that he could not be here this morning, but he has asked that his statement be inserted in the record at an appropriate place. Also, he wanted to have a brief statement talking about testimony from the Vietnam Veterans of America, which was not presented here today, but is available on the press table. It deals with, among other things, what we were just talking about; the quality versus quantity issue, and, in addition, wanted to have become a part of the record a small article that appeared in this morning's Post, concerning Mr. Derwinski's views of the VA.

So those will be put in the record.

[The prepared statement of Senator Murkowski and newspaper article appears on p. 106.]

Mr. **PTAK**. I just have one small question that Senator Murkowski asked me to ask.

According to Veterans' Administration data, over 50 percent of the category A veterans being treated in VA fall into category A because of their income.

Now, the question is: Of the category A's being treated at your facilities that you have come in contact with, how many are actually service-connected veterans, and of these, how many are receiving treatment for their service-connected disability?

Start at the right-hand side.

Mr. **DEGASTA**. I am thumbing through my notes. I'll have to defer to my notes. I'm sorry.

Mr. **HOLTHAUS**. I am not exactly sure of the exact percentage of those. Of the category A's, the last count was approximately 35 to 40 percent, as best as I could gather.

Mr. **PTAK**. Of the category A's, which includes quite a few people.

Mr. **HOLTHAUS**. Right.

Mr. **PTAK**. Of the actual service connected.

Mr. **HOLTHAUS**. Right. That's, I think, a fair percentage.

Dr. **PARTHEMORE**. At my satellite outpatient clinic, which sees approximately 60,000 visits, it's around 70 percent. At the hospital, which sees closer to 200,000 visits, it is more like 30 to 40 percent.

Dr. **THREEFOOT**. That is similar to the figures that I gave earlier. Of inpatients, 33 percent of category A are service connected. Since 97 percent of our patients are category A, 32 percent of all patients are service connected.

I cannot answer how many are receiving treatment for their service-connected disability.

Of outpatients, of the 200,000-plus that we see in New Orleans, approximately 35 percent of the category A's are service connected. Of the 30,000 outpatient visits to our Baton Rouge satellite, 58 percent are service connected.

Ms. **Pope**. I don't have that information.

Mr. **Ptak**. I was going to say, for those of you that do not have it, or if you wish to just get it at a later day, we can put that in the record.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

	Fiscal year—	
	1988	1989
Service-connected admissions applications	6,269	[1] 3,436
Service-connected veterans admitted	1,997	[1] 1,061
Number of service-connected outpatient visits	6,630	[1] 5,095

[1] October to March.

At the Loma Linda VA Medical Center, 48 percent of our caseload are service-connected veterans. We do not track the percentage of veterans being treated for their service-connected disabilities. Thirty-four percent are non-service-connected veterans who are category A because of their low incomes, 2.8 percent are category B, 2.1 percent are category C non-service-connected veterans, and 9.2 percent of our caseload are nonveterans. Of these nonveterans, 8.1 percent are collateral visits. These are staff visits to family members of veterans to provide them with education and training on how to provide care for the disabled veteran relative. The other nonveteran visits are humanitarian emergency treatments provided to nonveterans, primarily visitors and employee health visits. There is also a small percentage of staff contacts that are logged in as unknown or unapplicable.

Mr. **DeGasta**. I did discover my figure. Of the outpatient veterans at the White River Junction VA facility, in excess of 40 percent of those are service-connected category A.

Mr. **Petty**. Loma Linda historically has treated a very high percentage of service-connected veterans. I don't have the exact figures with me, but I will obtain them.

Mr. **Ptak**. Thank you very much.

Mr. **Mullon**. I also will obtain them. The last figure that I can recall is 44.2 percent service connected. How many of those are treated for service-connected conditions, I'll find for you.

Ms. **Wilson**. The same here. I will submit that for later, because I don't have that information.

Mr. **Ptak**. That would be great, and again, I think your testimony was very thought-provoking. And I have also been asked if I could have a statement by Senator Thurmond inserted.

Mr. **Steinberg**. We will be delighted to receive it now. Thank you.

[The prepared statement of Senator Thurmond appears on p. 111.]

Mr. **Ptak**. Thanks very much.

Mr. **Steinberg**. Al, I am going to be asking several more questions, but I want to invite you, if in the course of the answer there is a point you would like to have clarified, to please proceed to ask for that clarification. I am not going to switch the lights on if you have no more prepared questions.

I am sure you are all aware that a supplemental funding proposal was submitted by the administration on March 24, which Senator Cranston referred to in his opening remarks, and certainly there is every expectation that Congress will provide supplemental funding this year, and, indeed, the House VA-HUD Appropriations Subcommittee marked up the supplemental legislation yesterday, and did provide approximately $37 million more for medical care than was requested in the administration request, as far as the information we have been able to receive is concerned.

But it is not clear at which point Congress will take action, and how soon money might reach the field, and I just want to reference this scenario and alert Dr. Gronvall that I will be asking him a question in light of this scenario as well.

The House is scheduled to take action on the Supplemental Appropriations Bill the third week in April. The Senate is scheduled to begin its consideration of the supplemental in the first week in May, and floor action is contemplated sometime around mid-May. And, with conference action necessary to resolve differences that will inevitably occur between the House and the Senate, that would probably take us at the earliest, to the end of May, when Congress is going into about an 8- to 10-day recess, until any legislation is sent to the President. I am sure an effort will be made to get that supplemental out of here before the Memorial Day recess.

That then means that there is a period of time which traditionally has been at least 10 working days, although presidents have, on occasion, signed legislation earlier, but you can't count on that.

Then there is an additional period that OMB takes to make what is called a fund allotment to the agencies covered by a particular appropriations bill.

Adding all those days, it seems reasonably likely—not to mention the amount of time that it takes for Central Office to get the money to you, but I would hope that that plan will be in place and that will happen very, very rapidly, so let's not enter that into the equation—that what we are talking about is probably money not reaching you until about July 1. And with that as preface, my question is: Will you have to take any further actions at your facility if you don't receive additional dollars until July 1?

We will start down here, if we can. Thresa, I don't know if you feel that you can answer that question, so——

Ms. Wilson. No, I couldn't answer that question.

Mr. Steinberg. OK. Why don't we see what Tom has to say about that.

Mr. Mullon. Well, right now, we are considering the possibility of closing down another ward. I am not certain that we would—if we had assurance that we were going to receive this in the fourth quarter and that the funds in the fourth quarter will be carried into fiscal year 1990——

[Laughter.]

Mr. Steinberg. What you mean by that is annualized, not carried in.

Mr. Mullon. That's correct. You are correct, yes, annualized in the fiscal year 1990. If we had assurance of that, then I think we would hold back on our plans at this point. And I don't know how you could be sure——

Mr. **Steinberg**. Your cutback plans is what you are referring to?

Mr. **Mullon**. That's right. Yes. And I think that's clear that it will help us to have additional supplemental funds this year. But in the fourth quarter, it is one-quarter of a year, it's going to have to be considered, and the future fiscal year is certainly a major consideration, because if you are going to have to reduce back beginning October 1, there really isn't an awful lot you can do on a continuous basis in the fourth quarter, and I certainly would still consider the closing of a ward on any of those circumstances if fiscal year 1990 money was not available.

Mr. **Steinberg**. What I might say with respect to the question of annualization in fiscal year 1990 is that, although waiting until July 1 certainly sounds like a very unattractive alternative, it has one advantage, and that is that at least the House by then will almost certainly have passed its fiscal year 1990 appropriations bill, and there is a reasonably good chance that it will have at least emerged from subcommittee or full committee in the Senate, which would certainly give parameters to the agency as to what the fiscal year 1990 levels will be.

I might further say that I am certain that the appropriations committees and their subcommittees, which are both chaired by new members this year, are very well aware, Tom, of the point that you have raised. And I think it is very unlikely that either they or the Congress will take action in fiscal year 1989 without a very clear recognition of and commitment to the need to follow through on the implications of that action in fiscal year 1990.

Those are, of course, nice words coming from merely a staff member, I recognize, but there has been a lot of discussion about this very point between the authorizing and appropriations committees, and we are hopeful that what I have said will indeed come true.

So I wanted to add that and move to Steve, if you have any comment to make on this.

Mr. **Petty**. I do. As I indicated earlier, even with all the cuts you have already made, we are still projecting a $1.5 million shortfall. And I am sure our director has additional cuts planned. What his timetable is, I don't know.

Mr. **Steinberg**. OK.

Ms. **Pope**. I know that there are some things being considered, but I would not be able to answer your question.

Mr. **Steinberg**. I understand that.

Sam?

Dr. **Threefoot**. We are still nine positions cumulative over what we have to get down to. I don't think that we can wait and see what is going to happen. We are going to still have to continue making cuts, because the longer we wait, then the more people we have to drop off to get down nine. If we wait until the last quarter, we are going to be in real trouble.

Mr. **Steinberg**. Do you agree with Tom that if there seems to be relative certainty that a supplemental will be forthcoming by the fourth quarter, that you would try to defer, or are you saying that you would go ahead regardless?

Depending upon what Central Office discretion is, what Central Office gives you in the way of discretion, of course.

Dr. **Threefoot**. I don't know how much faith our director has in promises. If there are no fences around the supplemental, it can be used to big advantage in such things as buying ahead and relieving some of the pressures that come up in either the next quarter or next year.

The biggest help that Congress could give to the field would be if there were a 2-year budget, because this business of hurry up and wait, or we haven't got any money so knock them off, and then we're going to have money, so put them on, is very, very demoralizing, particularly to the physician staff that I have to deal with. They get so they don't believe us, so when we ask them to go slow, to cut back, to please be frugal, they say, "Oh, why? We're going to get the money later, we always do." And it's because of this sawtooth curve we operate on.

Mr. **Steinberg**. We understand that.

In order to move things along, I am going to ask each of you if you have something to add to the questions, or if you want to just concur in remarks previously given in response to a question, to do so, because we want to cover some more ground and we are never going to finish if we go on this way.

Jackie?

Dr. **Parthemore**. I think the only thing to add is that it is impossible to hire professional staff with short-term dollars. They won't come to work for you if they know it is only for a few months, and there's a lag time to get them in. It only helps in that those dollars end up paying for gardeners and other sorts of people who aren't involved in direct patient care.

Mr. **Holthaus**. In addition to all the other actions that we have taken, we may have to further reduce our contract nursing home placement. Additionally, as I mentioned earlier, we are still holding all of our equipment and our nonrecurring maintenance moneys to pay for salaries.

Mr. **DeGasta**. I can cut no more, Mr. Steinberg. I have done all I can—closing programs, limiting access to category B's and C's. I can do no more. My programs are bare bones. Beyond what I have done, I can do nothing more. I'm hopeful that a supplemental will provide us with the ability to put some of our programs back on line.

Mr. **Steinberg**. I am going to ask you to respond to this question in writing for the record, if you would, please, and that is: What steps would it be likely that you would have to take at your facility if no additional funds were provided for this fiscal year?

Mr. **Steinberg**. And let me move from that question which we are asking in writing, asking for your response in writing, to ask that, is it fair to assume that your expectation is that when you get supplemental money, that is going to enable you to pay back the fourth quarter from which you have already borrowed substantial money, and that, in essence, the level of supplemental money that is now generally being talked about is not going to enable you to move back to where you were in fiscal year 1988?

Let's start with Gary on that. Is that a fair assumption?

Mr. **DeGasta**. I am not sure I understand——

Mr. **Steinberg**. Have you already borrowed?

Mr. **DeGasta**. Absolutely.

Mr. **Steinberg**. So that when supplemental money comes, it will actually enable you to sustain your current level in the fourth quarter, rather than enable you to expand in any significant way from where you are now?

Mr. **DeGasta**. Absolutely. I think Tom Holthaus has made a comment that he had not purchased any equipment. I have done the same as he—not purchased significant medical equipment in about 2 years. If I had any excess moneys, excess in quotes, I would certainly pump it into medical equipment to give my staff the tools they need to do their job.

Mr. **Steinberg**. So we are not contemplating that this additional supplemental money will enable you to make any significant expansion in workload such as moving back to workloads that were nearly approximating the 1988 level in terms of B and C care, for example?

Mr. **DeGasta**. I would just love to be in a position to restore the programs I have eliminated and the services I have cut.

Mr. **Steinberg**. But you don't expect to be, do you?

Mr. **DeGasta**. No, sir.

Mr. **Steinberg**. Tom?

Mr. **Holthaus**. I wouldn't expect to be either. Whatever the supplemental would be, I would have to buy some of the equipment and do projects.

Mr. **Steinberg**. Jackie?

Dr. **Parthemore**. The supplemental to my hospital would have to amount to $5 to $6 million to be able to restore what we have cut in this year, and I don't expect to get that amount of money. I think the only thing that we hope the supplemental will accomplish for us is to allow us to close out the fourth quarter at the level we are working now. If there are any additional dollars, they would go for equipment or for stocks on the shelves, which generally are bare.

Mr. **Steinberg**. Sam has nodded his agreement with that, so I will——

Dr. **Threefoot**. It will be a pretty dismal fourth quarter.

Mr. **Steinberg**. Is this generally the situation?

[Affirmative nods.]

Mr. **Steinberg**. Everyone has nodded affirmatively. We will move to another question then.

Let's start with Steve Petty and Anne Pope on this question, and that is: Where do you direct category B and C veterans to go for care that the VA is no longer able to furnish, and what is your general experience with those referrals? Are those veterans getting care, and if so, from where?

Steve, do you want to start?

Mr. **Petty**. For a number of veterans, the alternative resources is health care financed through Medicare, and there are a number of veterans that do have Medicare. However, with our cutbacks on B and C veterans, in some instances we have played a bad joke on some of these veterans, because they have elected not to have Medicare Part B, feeling they have been able to depend on VA, and now they have been discontinued because of modest incomes, and there is only certain times of the year that a person can enroll in Medicare Part B.

Then there are those that don't qualify for Medicare, such as the female veteran that I described, because they are too young. And, in some instances, I am afraid that the only alternative is to spend down whatever savings or assets or resources they have to poverty level to qualify for Medicaid.

Mr. STEINBERG. Do you think that there is a significant number of B and C veterans who are not getting care that they need, as a result of your inability to take care of them?

Mr. PETTY. Yes.

Mr. STEINBERG. Anne?

Ms. POPE. We have not discontinued the B and C category veterans as yet from our outpatient clinic. We had tooled up to do so, but with the information coming from CO, we stopped. However, we have tried to get ourselves ready for that, feeling that it is just really right around the corner.

We have seen a number of B and C patients who have come to the admitting area and have not been hospitalized. We have tried to develop resources and we have been referring them to community, a variety of community, clinics at some of the medical schools that are nearby, Medicare and private funds. We also try to help people to see how they can spend down to qualify for Medicaid. Yet we know that there is a sizable number of people there who are not seeing anybody at all.

Mr. STEINBERG. So you agree with Steve that there are some who are just not getting care that they need?

Ms. POPE. Oh, very definitely. And what they do, they wait until there is a real emergency—what may have been a non-acute situation becomes a very severe one. They perhaps can get in on the basis of an acute circumstance or an emergency situation, for that one time.

Mr. STEINBERG. Do any of you have anything to add to this question of whether you think that there are some of these veterans at your facility who are no longer being treated, who were treated previously, who are not getting care that they need?

Tom, do you have any comment on that?

Mr. MULLON. I will be glad to provide letters from veterans on this issue. I have specific examples I could read into the record now, but I don't want to tie you up with those. But I have examples of where these veterans are going for their care or they are receiving no care at all.

Mr. STEINBERG. That would be very helpful if we could have that.

[The letters referred to are retained in the committee files.]

Ms. POPE. I would like to give just one example, if I may.

Mr. STEINBERG. Sure.

Ms. POPE. We recently responded to a congressional inquiry about being unable to perform a heart transplant surgery for a veteran who is pensioned because his household income exceeds $30,000. His wife is employed. I don't know where they are going to get that care, because $30,000 in Chicago, for I guess a $50,000 procedure, gets to be very costly.

Mr. STEINBERG. Do any of you have anything to add on this question of whether veterans are not getting care?

Jackie?

Dr. **Parthemore**. I think the only other thing I would add is what was alluded to by the service officers and others, and that is if you have waiting times, for certain procedures in particular, or caps on the amount of those procedures that you can provide because you don't have enough in your budget for implantables, if patients have to wait 2 or 3 months or longer, even category A patients choose to go elsewhere.

Mr. **Steinberg**. Tom, do you have anything to add, or Gary?

Mr. **DeGasta**. I also have some vignettes which I can make available to the committee.

Mr. **Steinberg**. We would like that very much. Thank you.

[The material furnished is retained in the committee files.]

Mr. **Steinberg**. Next we would like to focus on your concerns and your impression of what's happening in the current funding situation to staff morale at your facilities, and what effect these funding problems are having on your ability to recruit and retain employees, particularly physicians and nurses, and, since we mentioned nurses last in that, we would ask Thresa if you would like to address what you see as the problems on staff morale and recruitment and retention at your facility.

And I want to have to ask you to each try to be very brief and concise at this point.

Ms. **Wilson**. I feel we do have a problem with recruitment. We are in an urban area. I mean, there are like four or five hospitals right down the street, down on Grand Avenue, where we are situated. The civilian community is tooling up with bonuses and special programs, special hours, things that VA are not able to match. And we are also hampered by the situation where once we get the personnel, we can get them through the door. Our work situation, our workload is so different from civilians that we cannot retain them.

We even at this point have long-term nurses considering leaving the VA, the ones that normally stayed regardless of what is going on with staffing, are leaving to go elsewhere.

Mr. **Steinberg**. Are you concerned about staff morale, then.

Ms. **Wilson**. Yes. Staff morale is at, from my point of view, being down on the wards with the patients and the nursing staff, is very low. And the numbers impact that most for the folks that are down on the wards with the patients, not getting satisfaction in their work, don't feel like they are being paid adequately for what they are expected to do, and not being able to do the other than direct care things.

Mr. **Steinberg**. So your perspective is the most important perspective, the hands-on direct care, and the other panelists are all shaking their heads affirmatively. So it is particularly valuable to us to have that statement about what's going on down there at the ward level.

So I am going to move on now and, Tom, if you want to comment on staff morale and recruitment or retention problems, or has she covered it fully?

Mr. **Mullon**. Fully. I always agree with my chief nurse, and I certainly agree with Thresa.

Mr. **Steinberg**. Steve or Anne, do you have anything to say in terms of staff morale in your services?

Ms. Pope. I would agree. I just want to add that we in social work now are also having difficulty with recruitment and retention, and that is a new phenomenon.

Mr. Steinberg. And you attribute that to funding reductions?

Ms. Pope. Funding reduction. Salaries are not competitive. As a private practitioner now, many social workers are moving into the private arena. They can make more money and encounter less frustration. This seems to be a general situation that is taking place.

Mr. Steinberg. Steve?

Mr. Petty. As I said earlier, my staff morale is at an all-time low because of demoralization from the frustration, not being able to provide the help that these people desperately need. In addition to the reason Anne has given, in and on top of that, I have had a high turnover rate, people have left because of this, with hiring freezes, and I have not been able to recruit, which has demoralized the remaining staff even further.

Mr. Steinberg. Sam, maybe you and Jackie would like to talk for a moment about physician recruitment in this environment, and physician morale.

Dr. Threefoot. Yes. The fact that we were not able to make a commitment to a gerontologist, boarded in gerontology, which we would have liked to have had, we lost her. She waited for 3 months and said, "Well, if you have to wait until July to tell me, I'm going elsewhere."

We have lost a psychologist who had been with the VA for about 15 years to a private hospital because of the salary. We also lost a social worker. We have been without a chief of surgery for 3 years because of problems in finding one that would accept at the salary they were able to get, even with university supplement.

Morale is low and, as I mentioned before. The physician staff morale goes down when we can't provide equipment and prostheses and replace or add to the CAT scan, which is overworked.

Dr. Parthemore. In my area, for physicians as well as in many other jobs, you are often able to recruit at entry levels because VA salaries are better there than they are for more senior staff, so that you tend to lose senior staff, be it physicians, nurses, pharmacists, or techs. You are always doing training.

We have a very difficult time getting the kind of people that we would like to get, in particular the more senior service chief jobs, and we have prolonged vacancies often in those areas.

I am helped by the fact that my medical school vigorously underwrites salaries for my physicians, so that physician salary at my institution has not been as critical. But the medical school is beginning to speak openly about the cost of affiliation with the VA, and whether or not it is worth retaining it.

I think that the kinds of problems that the hospitals are coping with may be the reason why there are more than 20 chief of staff vacancies with more expected in the VA. You do it for the love, because there is not a whole lot else, except frustration, and in the hope that you can help in making some wise decisions or better decisions for an institution that you care about.

Mr. Holthaus. I certainly concur with everything that was said by my peers, but I also would like to add, at Togus, some 10 years ago we had a very, very low turnover. However, now, with the many problems with the salaries that we are paying and the proper support for the units, we also are seeing nurses that are leaving every day. For example, right now in our medical and surgical unit we've got about 15 to 20 vacancies. We have prolonged vacancies of occupational therapists, physical therapists, psychologists, and medical records librarians.

Mr. **DeGasta**. Just one comment to add to what has been already said. We have had problems recruiting. It took us 2 years to replace a general surgeon. It took us 2 years to replace a vascular surgeon. We just replaced a radiologist position which had been vacant for nearly 2 years. The problem we face is our inability to offer comparable salaries to attract the quality of people we want to have in an affiliated program.

I would also like to make a general comment about our pay system. We talk a lot about pay for physicians and nurses. I think the pay for the other people who work in our organization is not keeping pace. People in our area can go to a local hamburger stand and make more money than we pay our nursing assistants. We are losing secretaries to the private sector because we cannot compete. We can have all the competent clinical staff in the world, but if we don't have the supportive staff for them, they are not going to be able to do their job.

I want to make one comment regarding morale. Currently there is a fear on the part of staff in my institution, as a result of the actions I have taken to reduce or close programs—"It really it isn't worth it, if a program is closed today, the hospital may be closed tomorrow." The very people we want to stay around, we're losing. Since I closed our programs, I've lost several experienced nurses who had been with us for 12 or more years. That's a fearful sign which I hope does not continue.

Mr. **Steinberg**. I yield to Al Ptak for a question.

Mr. **Ptak**. Thanks, Jon.

I am the new kid on the block, so this has been very helpful for me, and I commend the chairman and Jon for having this hearing.

But as it has gone along here, it has kind of made me think of some things, and I have heard about the quality of care, recruitment, equipment, morale, retention. I guess I have two quick questions.

Number one is: Other than the obvious, which is more money, do any of you have any little pet ideas that you think are ways to be more efficient, that maybe you thought about? All of you have so many years in the VA system, that you may want to just throw out.

And the other thing is, I was thinking about the fact that there are a lot of new facilities either being planned or being built or have been built, such as the hospital, the beautiful hospital in Minneapolis.

Do you feel that you have sufficient power or input to, when you see a facility that is either on the drawing board or is being planned, being funded, being built, where you can say, "Hey, I know enough already to know that we can't staff it, we can't afford it, we don't have the nurses and the doctors to man it. I know we can't afford the equipment to put into the new hospital." Do you feel that you have had an input to go back to the VA and say, "You might as well stop because we don't have the resources," that once this building is built—certainly I don't mean to pick on Minneapolis, but the fact that it is a beautiful building, but you are thinking about closing down a ward or not being able to maintain it, and that sort of thing. At what point are you able to say, "Gee, maybe we shouldn't do this," or, "Maybe it shouldn't be this big," or that sort of thing?

Dr. **Threefoot**. You asked for ideas. Last year, I was President of the National Association of VA Chiefs of Staff, and regret that I was not able to testify before this committee in September due to illness, and Dr. Wendell Musser did a very fine job. As President of NAVACOS, I accumulated from chiefs of staff all over the country ideas, principally for discussion at the meeting which was held in Chicago in conjunction with the AAMC last November.

Dr. Musser continued and got further ideas, which I think he has presented a paper to the staff through this committee, which includes quite a few ideas concerning consolidation of the VA in certain areas. There is also——

Mr. **Steinberg**. If I can interrupt, we will enter that document into the record right at this point.

[The document referred to is retained in the committee files.]

Dr. **Threefoot**. At the present time, the Regional Medical Education Center in St. Louis is putting together the agenda for this program this coming November, which will be held here in Washington, and by the Delphi method, have gotten responses from a large number of directors and chiefs of staff, which include the necessity of relooking at the VA, reorganization of the VA, to meet the budget problems, and to try to operate more efficiently.

Now, whether that means closure of certain facilities, that suggestion has been made, I am sure, ever since some were opened. But those ideas, which we don't need to elaborate on here, have been presented in Dr. Musser's paper and will be discussed in the meeting, the Senior Management Conference of VA directors and chiefs of staff in November, the last of October and first of November here in Washington.

Mr. **Ptak**. Jacqueline?

Dr. **Parthemore**. I think a number of us are also involved with regional planning. For instance, in my region, which is the Western region, I serve both on the regional planning board and chair the high tech task force, and we have looked at things like how many of anything do we need. Many hospitals need cath labs and MRIs—and virtually all of the secondary and tertiary care hospitals need CT scanners or upgrades, but we can probably get by with one lithotripter in each district. We are trying to plan the regionalization of resources. Likewise, we have looked at transplant programs. The only way to fund them is to create a pool, like an insurance pool, for transplants that we all contribute to, because you never know at which hospital the patient needing a transplant is going to present.

We are trying to approach it in these ways, realizing that there just aren't enough dollars to meet the needs. There are a whole host of new medical technologies that are coming along that I have no idea how we are going to fund. Automatic implantable cardiac defibrillators are an example. It's a big expense—$18,000 just for the hardware placed in the patient, and $13,000 to replace the battery every 1 to 2 years. The cardiologists tell us that we are going to be seeing a lot more of this being used.

I don't know how we are going to meet that demand with budgets that are decremental.

Mr. HOLTHAUS. In our region, we are constantly looking at the entire mission of all the medical centers, and I think we have to continue that, whether we need all the medical centers that we have or we need some mission changes. I think also, though, we need some flexibility as far as what we can do with our resources at each individual hospital. You know, we've got so many rules, regulations. We've got the FTE ceiling census and all these things that everybody is aware of.

Also I believe, though, in our entire construction program, if a medical center, the idea comes forward and it is approved by everyone today, for example, it might be 7 or 8 years or maybe even a few years longer than that before the doors are actually open and before you actually accept a patient.

Now, we all know there is unbelievable many, many things that can happen between now and 7 years, and I think that is a real crucial area in which we in the VA need to shorten the timeframe.

Mr. DEGASTA. My only comments will be that if Congress and the administration choose not to support the VA with the tools and the dollars it needs to run our current facilities, our policymakers in Washington, Dr. Gronvall and other members who lead our organization, will have to make the decisions whether or not we can afford, as Tom said, to operate all the facilities we are currently running. These are very difficult policy decisions which are certainly beyond those of us sitting at this table.

Mr. PTAK. One last comment.

I want to just commend Dr. Gronvall, who has been here since 9 o'clock, and probably would like to be back at his office taking care of some of the problems that you mentioned for the last 2 hours. But he has been a good trooper, sitting here in the audience.

Thanks, Jon.

Mr. STEINBERG. Thank you.

We are about to conclude. Senator Cranston mentioned at the outset that he was going to ask you to speak generally about funding resources and their implications, about the shortfall in funding resources, the implications at your facilities. It would seem as though that is no longer necessary at this point in view of enormous breadth of the ground that you have already covered.

What I would like to do, however, is to offer you each about an additional 30 seconds or so to make any particular point now that you would like to make that you haven't made up to now, to enlighten the committee about the implications in the field of the current funding restrictions, with a particular view to the extent that you can, to the impact of that on individual veterans, which is one of the principal concerns we have at this hearing.

And we will start in the middle with Anne and move to her right, if that is OK.

Ms. POPE. I would just like to share one example that has to do with an elderly couple that had been provided respite care, which gave the wife a break. She was willing to take him home. On return request for respite care, we had to tell her that we could not take him back into our respite program because he was category C. We are no longer accepting category B and C patients in respite.

She said, the VA never asked him how much money he made when they took him into battle in World War II. Now all of a sudden you want to know how much money he has got.

I think that kind of summarizes where we are with the people we are trying to serve.

Mr. STEINBERG. Steve?

Mr. PETTY. I would like to use my 30 seconds to share another case example.

This involves a 74-year-old veteran the VA has treated for the last 2 years for cancer of the head, requiring removal of significant portions of the lower jaw, making it nearly impossible for the veteran to eat in the normal manner. In the veteran's chart there is a note from our ENT oral surgeon stating the patient needs bone graft to rebuild the mandible. A note back to the ENT from the oral surgeon states that reconstruction surgery is feasible.

And on December 28 there is a note that the patient wanted to go ahead with the reconstructive surgery. On February 1 he got another one of those letters saying we are sorry, we can't afford to take care of you any more.

In general, there are a number of veterans who are going to go without treatment. There are a larger number that are going to be in extreme financial difficulties and some who will simply die.

Mr. STEINBERG. Tom?

Mr. MULLON. Very simply, patients are losing faith in our system. Our service organizations are losing faith in our system. Our staff are losing faith very quickly in our system. Unless we reverse things pretty soon, we aren't going to have any system.

Mr. STEINBERG. Thresa, do you have some concluding remarks?

Ms. WILSON. Yes. Just for my own general information, over the last year, I would say we have had an increase in patient complaints, family complaints, and they are all, you know, over patient care. They may not be directly involved with nursing care, but all aspects of care. And I concur with everything everyone said. The person that winds up suffering ultimately as much as the staff is suffering, is the patient.

Mr. STEINBERG. Sam?

Dr. THREEFOOT. What I would like to do is just read a short statement from the Chief of Orthopedics.

Mr. STEINBERG. Can you do it in 30 seconds?

Dr. THREEFOOT. Yes.

Mr. STEINBERG. OK.

Dr. THREEFOOT. In reference to many patients, it was summarizing some patients.

> The main reason that these patients are going to have to have surgery is to relieve the pain in their joints, improve their functional capacity, and improve their quality of life. Many can only ambulate with the assistance of cane or crutches, and some are wheelchair bound because of pain and deformity. The total joint replacement would alleviate their pain. If surgery is further postponed, it is possible at a predictable time in some patients they will continue to deteriorate, they will become bedridden.

And then he cites what happens when they become bedridden, leading to pneumonia and other——

Mr. **Steinberg**. Would you like to submit the rest of that document for the record?

Dr. **Threefoot**. Yes, I can.

Mr. **Steinberg**. With any appropriate modifications you might wish to make.

[The document referred to is retained in the committee files.]

Mr. **Steinberg**. Jackie, your concluding remarks?

Dr. **Parthemore**. I certainly have examples such as those given that are specific to my hospital. I would only say that not only is the VA hospital system an excellent resource for veterans, but I think it represents a truly great opportunity in health care as a laboratory for undertaking innovation in patient care. It already provides outstanding research. And I think there is much to be lost, beyond what we already know is happening to individual veterans, as it begins to involute.

Mr. **Steinberg**. Tom?

Mr. **Holthaus**. We really cannot afford to further reduce any of our programs at Togus without jeopardizing our basic mission of providing the basic medical care, surgical care, and psychiatric care. If we reduce—and I agree with all my colleagues, we will be losing the confidence, or losing more confidence of the veterans and we would be losing staff.

Mr. **Steinberg**. Gary?

Mr. **DeGasta**. I would like to conclude by quoting from a letter I received from a category B/C veteran in response to my letter denying him access to care. His letter reads as follows:

> I received your correspondence. I want to take this opportunity to say that I have been very happy with the professionalism and humanitarian type care and treatment that I received for the past ten years in all departments. From the many comments I have heard from other patients, many of whom were transferred from other medical centers, I know that I am not alone in my thinking the many doctors and nurses and support personnel deserve much credit.

He goes on to say:

> I trust that Congress, in its wisdom, in this session or near future sessions, any move to fill a great need to improve the health maintenance and health care programs provided to citizens of this country, will allocate funds to reinstate and expand programs of a health care nature. I hope that additional funds will be made available to the Veterans' Administration so that the veteran segment of our society will again be able to be welcome at Veterans' Administration health care centers.

He goes on to close and says,

> I hope we can some day reestablish our relationship and, in the meantime, continue your high standards.

These are very praiseworthy comments from a veteran I was forced to deny access to care.

Mr. **Steinberg**. As a final summation, our September 9 oversight hearing that Senator Cranston referred to earlier and in Sam Threefoot's reference as well, Senator Cranston asked a panel of witnesses very similar to yourselves in composition, as well as four regional directors who testified, all together about 13 witnesses, the following two questions, and we would be very interested in your response.

The first question was: In your opinion, does the VA face a crisis at this point? Is that a fair word to characterize the funding situation that we are experiencing at this point?

Gary, why don't we start with you. And I would like to ask you to answer just yes or no. If your answer is no, you may want to explain briefly why you don't think that is accurate.

Mr. DEGASTA. Absolutely.

Mr. HOLTHAUS. Absolutely.

Dr. PARTHEMORE. Absolutely.

Dr. THREEFOOT. Yes, and I think you can look at the VA as being a patient and Congress as being the physician. The patient is sick, not in the early stages, but if not treated soon, will result in a chronic disability terminating in death.

Mr. STEINBERG. Anne?

Ms. POPE. Yes.

Mr. STEINBERG. Steve?

Mr. PETTY. Yes.

Mr. MULLON. Totally agree.

Ms. WILSON. Yes.

Mr. STEINBERG. That was certainly the tenor of the testimony we had on September 9. The second part of that question from Senator Cranston on September 9 was: Is this the worst fiscal crunch that you have ever seen the VA confronting in all of your experience in the VA?

We'll start with Thresa.

Ms. WILSON. Like I said, I'm the novice. I have only been in the VA 8 years. But, in my experience, this is the worst, the last 2 years.

Mr. MULLON. I can't remember any worse than this, Jonathan.

Mr. PETTY. Nothing in my 22 years comes close.

Ms. POPE. It's the worst that I have seen.

Mr. STEINBERG. Sam?

Dr. THREEFOOT. Yes.

Mr. STEINBERG. Jackie?

Dr. PARTHEMORE. Absolutely.

Mr. HOLTHAUS. It is the worst I have ever seen in my 25 years.

Mr. STEINBERG. Gary?

Mr. DEGASTA. The same here.

Mr. STEINBERG. Thank you all very much. Your testimony has been remarkably lucid, informative, and helpful, and we are very grateful to each of you for traveling such great distances to be with us.

We are going to make available to each of you a very informative letter which we received yesterday evening from Secretary Derwinski, which I believe was the result of some effective work performed by the Veterans Health Services and Research Administration.

This letter explains what the money in the supplemental is intended for, and also answers a number of questions that Senator Cranston asked about specific areas that will or will not be addressed. And so we will make a copy of that available to each of you, and I will, on the record, apologize, Al, if you do not have that, a copy of that letter.

You do have a copy.

Mr. **Ptak**. Yes.

Mr. **Steinberg**. We received it about 6 or 6:30 p.m. last night, and there wasn't a lot of intervening time, but I am glad that has occurred.

So we will make that available to each of you. I think you will find it enlightening. We hope you will be able to stay to hear Dr. Gronvall, who will testify next. And again, we thank you all very much.

Dr. Gronvall, would you please join us?

TESTIMONY OF DR. JOHN A. GRONVALL, CHIEF MEDICAL DIRECTOR, DEPARTMENT OF VETERANS AFFAIRS

Mr. **Steinberg**. I want to echo the sentiments of Al Ptak about our gratitude for your being with us and remaining with us, and your interest in and attentiveness to the testimony of the panel that has just concluded.

I would also like the record to note that approximately 50 minutes ago I said if you need us to, we will set the panel aside and go to questioning of you, and you very graciously responded that you are here for the morning, and we appreciate your patience and your generosity.

Dr. **Gronvall**. Thank you.

Mr. **Steinberg**. I would like to take a moment or two to go over a few questions arising out of the April 5 letter that I just made reference to, and again, thank you very much for all of the work of you and your staff in putting together a very informative response to Senator Cranston's April 3 letter.

We realize that these responses do not fall to Earth out of thin air, and we appreciate the effort that went into it.

I just want to read briefly from Secretary Derwinski's letter. It says: "The supplemental will not permit any significant increase in services to category B and C veterans above the level of services now being provided. Without a supplemental, a significant decrease in employment,"—and you later explain that to be about a 4,000 FTEE decrease—"and outpatient workload,"—and I think that turns out to be about a $933,000 decrease—"was anticipated * * * The supplemental * * * will not provide for increases in services or employment from current levels."

The letter further states, on page 2, that the supplemental will permit an augmentation of $32.1 million in activations funding.

What it does not state is how far that $32.1 million will go in restoring you to the activation schedule that you had originally projected for fiscal year 1989, so I will ask you that question. How close will that enable you to come to meeting that activation schedule?

Dr. **Gronvall**. I believe, Mr. Steinberg, that question can't be answered with a single precise answer. We had, as you know, borrowed some $46 million from activation budgets planned for the fourth quarter of fiscal year 1989. The proposed supplemental, as this memorandum says, will restore that $46 million. The total activation budget that we started with this year was significantly below the amount that we had previously judged necessary to do all of the activations, and that is why we are proposing to add some $32 million in addition to restoring the borrowed $46 million.

Part of the answer as to how close we can get back to the original activation schedule depends on when we get the supplemental. For a significant part of the equipment that is needed to install in a new facility, there is a 3, 4, or often 5 or 6-month time between placing the order and the receipt and installation of the equipment.

So when we had to defer the placing of orders, because we didn't have the money, a 6-month delay gets built in for some items from the date that we get the supplemental.

Mr. STEINBERG. And is irretrievable?

Dr. GRONVALL. It is irretrievable because we have no way to obligate the funds in the absence of an actual appropriation. So if we don't get the supplemental funding until July 1, we obviously have the orders all ready, they've already been reviewed. We can immediately begin to place them. But there will be significant slippage in the schedule. All of the projects will be activated, but there will be a significant slippage.

It would be a matter of a considerable amount of detailed analysis to review the project list to give exact answers about each project. There are some 100 projects scheduled for activation in the fourth quarter. We would have to look at each one and the actual list of equipment required, make an assumption about when we have the money and what the delay would be in delivering and installing the equipment.

But, in short, there will be a significant delay, although the supplemental will allow us to activate all the projects that had been previously planned.

Mr. STEINBERG. I note, on page 2 of your letter, the reference to the establishment of a special priority for restoration of funds for substance-abuse programs. Senator Cranston was extremely pleased to see that and certainly congratulates the Secretary and yourself on that priority. There is also an indication that a portion of funds will be directed toward the readjustment counseling contract program. I believe that that program has been reduced by $1.2 million in fiscal year 1989 at this point.

Can you tell us whether or not the full $1.2 million will be restored?

Dr. GRONVALL. No, I don't have that level of detail. I would have to provide a followup response.

Mr. STEINBERG. Would you provide that for the record, or perhaps it would just be a pro rata portion of the $1.2 million?

Dr. GRONVALL. Yes.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

Thus far the Readjustment Counseling Service has identified a fiscal year 1989 additional need of $900,000. There may or may not be additional operating deficits above that amount. Approximately $900,000 will be provided for readjustment counseling when the supplemental is received. However, the exact amount will depend on further analysis of operating deficits, the actual month in which the supplemental is received, and other priorities.

Dr. GRONVALL. Once again, all of those actual decisions will be influenced by the point in time at which we receive the actual funds. There are some actions that we would like to take that if funding is delayed until July 1, could not be fully implemented.

Mr. **Steinberg**. At the bottom of page 1, in answer to Senator Cranston's question, you say, to increase employment to 194,710 by September 30—and for those in the audience that may not be aware, that is the figure that Congress believed it was mandating for the FTEE level for fiscal year 1989—to increase employment to that level, additional funding of $26 million above the $303 million supplemental would be required.

Our question about that, John, is, does that not also assume the reprogramming of the $11 million that you have requested out of beneficiary travel funds, so are we talking about a level of $329 million or are we talking about a level $340 million in order to reach the 194,720 by the end of the year?

Dr. **Gronvall**. We're talking about $340 million.

Mr. **Steinberg**. And that is approximately the level, as I indicated earlier, the exact level according to my notes is $340,125,000, that the House subcommittee has recommended, which does not include the language that you requested with respect to beneficiary travel.

Dr. **Gronvall**. The House committee had previously asked us that same question about the funding level and we supplied similar detailed information. That is the figure that is in their markup and it's the basis of my answer here today.

I do need to add a very key point to that, that figure and that projection of even the feasibility of beginning to increase our enrollment was based on an assumption that we would have that decision and the funding in April. We are now at an actual staffing level of about 191,200. If we were to begin actions to build up employment, that takes time. There has been good testimony today to that effect.

Once again, the later we go in the year, that figure becomes invalid and the feasibility of intelligently and appropriately increasing staff becomes much more difficult.

Mr. **Steinberg**. That $37 million which is the amount that would go for that above your request, would, on July 1, go a lot further on the one hand but, as you are suggesting, on the other it would be very difficult just administratively to bring on board in the last quarter alone a sufficient number of additional FTEE to bring the level to the 194,720.

Is that correct?

Dr. **Gronvall**. Absolutely, and the later it goes in the year, if we were in the unfortunate situation of being forced to add employment in a very short time, again there has been testimony here from our field staff that the only way you can do that is by hiring large numbers of temporary, part-time people, commonly referred to as grass cutters, and that you are not able in that kind of a short-term crash effort to add the sort of professional staff and the appropriate mix of people to provide a balanced medical care program.

So we surely want to avoid being in that position.

Mr. **Steinberg**. We would certainly share that sentiment and that concern, and perhaps, in the course of the appropriations process, it can be handled with language which is somewhat softer than the language which has been used in the past. Recognizing, of course, that if the language is softened, we may not have the statutory requirement that OMB will have to give you the allotment of that ceiling and we may well be in a situation where, on the one hand, we soften it up to let you make good policy and, on the other hand, in the process permit you to be precluded from increasing staff above that estimated in the President's budget. So it's a difficult line to walk.

Dr. GRONVALL. I thoroughly agree, and the only additional comment I would make, really, would be to emphasize the first paragraph of the Secretary's letter calling attention to the fact that prompt action is really critical. I think we are in the fortunate situation now of having, as you said earlier, strong statements in the Congress about the need for additional funds, and now an administration request formally before the Congress. There is total agreement between the executive branch and the Congress, as best as I can tell, that the additional funds are needed, and so this hearing is helpful to call attention to the urgency of that in the context of what the funds will be able to accomplish.

Mr. STEINBERG. Have you requested a deficiency apportionment in anticipation of this?

Dr. GRONVALL. No, we have not, but our staff is reviewing carefully the exact timetable of actions we would have to start taking if we don't have supplemental funds in order to further constrain our operation to live within the existing appropriation. And consideration of a request for a deficiency apportionment would be in that consideration.

Mr. STEINBERG. I would hope that that would be given high priority and that you would take that message back to the Secretary and our good friend, the Deputy Secretary. I would think you would find a lot of support for that. I very much doubt that the schedule is going to be any faster than the schedule I outlined. But things always have a way of changing up here, and this is a difficult process to make predictions about.

As you know, your supplemental is part of a larger supplemental of over $2 billion, although you are certainly, not the medical program but the VA, the lion's share of that. There are other programs that would come within the category of dire supplementals, and the House is putting together what the mix of that will be.

There is the question of whether the Contra package will be included within that or will move forward separately. And the schedule that I indicated earlier that you obviously heard is the one that the Senate Appropriations Committee gave us at the beginning of this week.

So if we are talking about Senate action on a dire supplemental, in mid-May, I think you can see how there isn't any possibility of having enactment until June. And then you have the apportionment problem, and I have never known OMB to make an immediate apportionment, even of dire supplementals.

I might ask you how long did it take OMB to apportion the $31.7 million that we appropriated last August?

Dr. GRONVALL. I don't have that at my fingertips, but what we do, of course, is at the time that a dollar figure is moving in legislative action, we go ahead with our action plan as to how to distribute it and, in a sense, we try to have that information in the hands of the medical centers even before we have the technical legal authority to obligate the funds.

Mr. STEINBERG. I understand that.

Dr. GRONVALL. As a result, we shorten the gap that comes about by that paperwork project.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

Congress passed the supplemental on August 11, 1988. The funds were received on September 14, 1988.

Mr. STEINBERG. Right, but that's the gap that would come as a result of your delay, but, until the apportionment reaches you, you cannot begin to obligate any of that money.

Dr. GRONVALL. That's correct.

If I may make a quick comment on the question——

Mr. STEINBERG. Please.

Dr. GRONVALL. You raised the question of deficiency apportionment earlier, hoping that we would have sympathy for interim actions while we are waiting for the final appropriation. Looking back on this year, we have had that kind of support within the VA, and primarily within VA. Our appropriation for this year invited the submission of a supplemental and, even prior to the time that the administration decided to submit a supplemental, we had support within the VA for taking the internal actions that have been described here as borrowing, borrowing from the activation accounts, et cetera, to try to maintain a level of operation higher than we otherwise would have been able to during the first 6 months of the year.

So I would anticipate that support will continue, particularly in view of what I said, that now both Congress and the administration appear to have agreed on the need for the additional funds, so it is a matter of getting the actual legislative enactment.

Mr. STEINBERG. Al, let me just take one more moment. I don't know if you have questions at this point, but I just want to complete this line for a moment, if I may.

When we talked about the figure of $340 million, it seems therefore clear that you are not taking into account the $20 million CHAMPVA funding that the letter refers to, which would actually bring that level $20 million higher if it were taken into account.

Dr. GRONVALL. Right.

Mr. STEINBERG. Am I correct?

Dr. GRONVALL. You are correct.

Mr. STEINBERG. And are there not in your spending plan areas such as your CHAMPVA projection where, unlike CHAMPVA, your projection was not fully accurate, but fell short, and where you are running substantially over in your obligational schedule?

Dr. GRONVALL. Yes, absolutely. Each year we, at the beginning of the year, of course, attempt to project each area of our budget, and I think within the limits of total management ability, come very close. But some accounts run ahead and some run behind during the year. It is always popular to point out in public the accounts where we are actually having to spend less than we had earlier projected, and portray that as new flexibility. The fact is, there are other accounts where we are having to spend more than we had earlier projected, and those supluses tend to wash out in the course of an individual year. So that $20 million is not a windfall or a bonanza, because it will be applied to other areas of the shortfall.

Mr. **Steinberg**. In order to illustrate that for the record, could you give us an account-by-account picture of where you stand as compared against your obligational projection, with each account showing plus and minus, so that we can put that in context?

Dr. **Gronvall**. Yes. We would be pleased to.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

The two major programs running below the budget are CHAMPVA and the Community Nursing Home Care program, which will be the basis for a reprogramming request. The current best estimate is for a savings of about $25 million in Community Nursing Home Care, which will be applied to needs in the Maintenance and Operation of VA Medical Programs.

Mr. **Steinberg**. And then, finally, just to conclude this line and then to yield to Al for any questions he has.

Would it be reasonable to ask you to get back to the committee, let us say, by a week from this Friday, on this question of a deficiency apportionment and where that stands, after discussing that internally with the Secretary and what action the VA may take in requesting that?

[Subsequently, the Department of Veterans Affairs furnished the following information:]

A Deficiency Apportionment request was signed by the Chief Medical Director April 10, 1989. It is presently being reviewed at the Department level.

Dr. **Gronvall**. I think if I could broaden your request, what we could do is provide a description of our plan starting now, and running through the spring and summer, based on a set of assumptions about when we would actually get the supplemental. That's a broader description than just responding to the question about deficiency apportionment. The deficiency apportionment would be part of that plan of attack.

Mr. **Steinberg**. I appreciate your assistance in my questions. I would amend my questions to so request, but to specifically request, also, a response as well on the deficiency apportionment, if you please.

Dr. **Gronvall**. Fine.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

VHS&RA will continue to employ approximately 191,300 FTEE and to maintain current workload levels until approximately May 19, 1989. On that date the available resources in VA Central Office for the funidng of nonrecurring maintenance, equipment and activations will be frozen. VHS&RA will assess the status of the supplemental and advise VA medical centers of the status for the timing of the Fiscal Year 1989 supplemental.

VA medical centers will be assured that the funding of reimbursements, terminal leave, wage board increases, special pay and other items traditionally funded by VACO, will continue. Present policies on the decentralization of non-VA workloads will continue and additionally VAMC's will be permitted to temporarily divert capital account funds into operational accounts. To the extent that VAMC's can support current workloads and employment from within their budget they will be requested to do so, but both employment and workload are expected to decline.

A proposed distribution of the supplemental ($303 million) and CHAMPVA reprogramming ($20 million) will be completed by May 1, 1989. Approximately $132 million will be required to restore the capital accounts used to support employment and $32 million to augment the activations account. An additional $16.5 million will be set aside for priority commitments of VHS&RA. These commitments include support for the substance abuse program, the readjustment counseling program and for the San Antonio and Ann Arbor Geriatric Research, Education, and Clinical Centers. The balance available, $142.5 million, will be earmarked for specific VAMC distributions.

The proposed VAMC distributions will be used to fund outpatient workload requirements, to support unfunded "all-other" cost needs, and to support additional community nursing home care census. Guidance on the preparation of a revised operating plan will be sent out in the near future. This guidance will specify that funds will be made available upon receipt of the supplemental and that increased employment levels and balanced workloads will be accomplished with the supplemented level of personal services and "all-other" dollars. Since the VAMC's will have only one quarter to restore workloads, the revised levels of workload will be substantially less than anticipated through an April 1 supplemental.

Mr. **Steinberg**. Al?

Mr. **Ptak**. Thanks, Jon.

I would just like to say briefly, I think the supplemental was good news, and I would echo your comment where you said that prompt action is critical. I think a lot of that, the onus is now back here, because, as you said earlier, the amount that you requested now may be significantly different if you don't have money until, let's say, the middle or end of July, for example, how you would use that money, and that sort of thing. And I would hope that when you finally get the money, there was a reference to hiring so-called grass cutters, and that sort of thing, looking at the big picture. And just in reading the letter, I thought it was a nice comment by Mr. Derwinski to say that he was pleased that the President's request will meet the most immediate medical care needs of our veterans, because I think that's what this is all about. So I thought that was a good line to put in the letter and appreciate your taking the time to wait for a couple hours and be here.

Thank you.

Mr. **Steinberg**. Thank you, Al.

Dr. **Gronvall**. Mr. Steinberg? I expect you have more questions, but there are at least two items that were on the table earlier in testimony and questions being asked, about which I would like to comment, whenever that might be appropriate.

Mr. **Steinberg**. We would welcome that right now.

Dr. **Gronvall**. OK. Senator Jeffords was here and raised a question about a figure that he had that 25 percent of the people we were treating were nonveterans. I do not know fully the source of that figure. I believe it is highly erroneous, or misleading. And I would like very much to get back to the Senator and his staff and try to pin that down as to the source of that figure and then provide very detailed information about the number of nonveterans who come to us, either military dependents or emergency cases of accidents outside of our hospitals, or through sharing agreements or on specific research contracts.

It is a very small fraction. Off the top of my head, I believe it approximates something like 1 percent, but I would like to provide very detailed information to respond to that question.

Mr. **Steinberg**. I am sure he would welcome that. We would welcome it. His staff person is here. But we will make sure—I am sure you will—that he sees.

Dr. **Gronvall.** I surely will.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

Discharges of nonveterans from DVA hospitals in fiscal year 1988 numbered 7,132, or 0.7 percent of the total. The distribution of these discharges by category of nonveteran was as follows:

Category of nonveteran	Nonveteran discharges	
	Number	Percent
Active duty—Army	1,058	14.8
Active duty—Navy or Marine Corps	1,450	20.3
Active duty—Air Force	592	8.3
Active duty—Coast Guard	35	.5
Retired military	753	10.6
Medically Remedial Enlistment Program	2	0
Merchant Seamen (USPHS)	2	0
Other USPHS beneficiaries	36	.5
Office of Workers Compensation	51	.7
Job Corps and Peace Corps	3	0
Railroad retirement	1	0
Beneficiaries of foreign governments	42	.6
Humanitarian emergency	817	11.5
Other contract reimbursable	139	1.9
Donors	30	.4
Special studies	1,456	20.4
Other nonveterans	463	6.5
CHAMPVA (Public Law 93-82)	108	1.5
Czech or Polish Armed Forces (Public Law 94-491)	83	1.2
Philippine Scouts/Commonwealth Army Vets	11	.2
Nonveteran totals	7,132	100.0

Data source: PTF SAS data sets at DPC Austin, using the Means Test and Category of Beneficiary/Period of Service variables to identify nonveterans.

Staff medical outpatient visits by nonveterans in fiscal year 1988 numbered 1,270,731, or 5.9 percent of the total. The distribution of these visits by category of nonveteran was as follows (outpatient categories are different from inpatient categories due to differences in the legislated eligibility criteria for outpatient care versus inpatient care):

Category of nonveteran	Nonveteran visits	
	Number	Percent
Employee health	433,256	34.1
Sharing agreements	105,248	8.3
Other Federal agencies	94,999	7.5
Collaterals of veterans	613,012	48.2
All other nonveterans	24,216	1.9
Nonveteran totals	1,270,731	100.0

Data source: VA Summary of Medical Programs, September 1988, Table VIa.

Discharges of nonveterans from DVA nursing homes in fiscal year 1988 numbered 23, or 0.2 percent of the total. The distribution of these discharges by category of nonveteran was as follows:

Category of nonveteran	Nonveteran discharges	
	Number	Percent
Active duty—Army	7	30.4
Active duty—Navy or Marine Corps	10	43.5

Category of nonveteran	Nonveteran discharges	
	Number	Percent
Active duty—Air Force	1	4.3
Czech or Polish Armed Forces (Public Law 94-491)	5	21.7
Nonveteran totals	23	100.0

Data source: PTF SAS data sets at DPC Austin, using the Means Test and Category of Beneficiary/Period of Service variables to identify nonveterans.

Dr. Gronvall. And then just one other question. The field witnesses were asked, and I want to preface this comment by saying how proud we are of the medical center directors, the chiefs of staff, the social workers, the nurses, on down through the cadre of people in our medical centers who, this year, are under the most difficult circumstances they've ever been in, providing humane and quality care.

I have traveled to many VA medical centers this year, and they are operating under a really very difficult circumstance, and I was proud of the witnesses who were here today. But they are representative of thousands of quality people across the country.

They were asked questions about the demand for services this year, and each of them responded from their own medical centers, but I do have nationwide figures, and so I can put that total question in context.

If we take the first 5 months of this year, namely, October, November, December, January, and February, for which we have comprehensive information compared to the first 5 months in fiscal year 1988, 151,649 veterans more than last year applied to the VA for care. In spite of that increased demand, as you heard, because of the financial shortfall, we have had to cut back on the number of patients we have treated, so we have cut back some 18,000 on the number of veterans we have been able to hospitalize, compared to the first 5 months of last year. The total number of outpatient visits we have been able to support in that first 5-month period has increased slightly.

So I wanted to give that national perspective of what the individual medical centers portrayed, namely, continuing expansion of demand and then a declining ability to provide hospital care and outpatient care.

Mr. Steinberg. Tell me, what was the figure for applications?

Dr. Gronvall. The increase was 151,649.

I can supply—I think perhaps the best would be for me to supply a follow-up that gives the actual figures for fiscal year 1988 and fiscal year 1989, the first 5 months, actual number of applications and the comparison.

Mr. Steinberg. That would be very helpful.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

The workload for the first 5 months of fiscal year 1988 and the same period of fiscal year 1989 is as follows:

Category of care	Fiscal year— 1988	Fiscal year— 1989	Difference
Applications for care	1,159,766	1,311,415	+151,649
Patients treated	473,388	455,655	−17,733
Outpatient visits	8,323,549	8,430,959	+107,410

Mr. **Steinberg.** Do you have anything further to add?

Dr. **Gronvall.** No. Those were the two points I wanted to make.

Mr. **Steinberg.** With respect to outpatient work loads, in the white paper attached to the Secretary's letter, which is entitled "FY 1989 Supplemental Action Plan", at the bottom of page 1, in item 2, you refer to medical centers being able to maintain outpatient work load at current levels, and then you show a revised plan of 21,385,000, if I read that correctly, in total, of the number of outpatient treatments.

Dr. **Gronvall.** Correct.

Mr. **Steinberg.** How does that compare to the level that was projected in the 1989 budget?

Dr. **Gronvall.** I believe the original 1989 budget has a different figure, and this work load plan was developed after we got our appropriation and reassessed our total shortfall and the new commitments that had come out of Public Law 100-322. So we made a new work load projection on that base.

Mr. **Steinberg.** Which was 20,452,000?

Dr. **Gronvall.** Yes. And I don't recall the figure that was in the original 1989 budget.

Mr. **Steinberg.** Supply that for us, please.

Dr. **Gronvall.** We will supply that.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

The original budgeted outpatient staff visit estimate for 1989 was 21,251,000.

Mr. **Steinberg.** On the next page, under item 3, there is a discussion of the all-important question of activations and supplies and equipment, and it's a little hard to understand from that. At another point, you stated, I guess in the letter, that this will not directly add any money to deal with the equipment backlog, but you later explained that it is going to restore money which was taken out of the supply and equipment accounts in order to fund other ongoing needs for which the supplemental money is designed. Have I completed the circle?

Dr. **Gronvall.** Yes.

Mr. **Steinberg.** We were talking about entering fiscal year 1989 with a supply and equipment backlog of about $532 million, if I recall correctly, and I am wondering if you, after we get through with all of these calculations, can get for us a figure as to what you anticipate the backlog will be at the conclusion of fiscal year 1989 under this plan.

Dr. **Gronvall.** Yes. We surely will supply that.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

Assuming the supplemental availability, the replacement equipment backlog estimate at the end of 1989 would be $531,914,000.

Dr. **Gronvall.** I don't have it at my fingertips. And I think I can explain the confusion, or the complication briefly, as follows: At the beginning of the year, we had a backlog of equipment needs. The amount of money in the appropriation for equipment this year was inadequate to erode that backlog. Further, we then had to take temporizing measures to borrow some of it to maintain our operation, and then pay that back when we get the supplemental.

So getting the supplemental will restore the equipment money that we borrowed, but that's only up to a level that was in the original appropriation, which was not sufficient to begin eroding the backlog.

Mr. **Steinberg.** Which means that we are not going to go below $532 million?

Dr. **Gronvall.** Correct. In fact, our projection is that the backlog at the end of this year, even with the supplemental, will be greater than the backlog at which we entered the year. And we can supply that figure and that projection.

I would add that we have heard from all of our medical centers the same comments as were made in testimony here, that deferral of equipment purchases has put the VA in a very precarious state. In past years, our medical centers were forced, really, by Washington level action, to utilize equipment money to hire staff. This year we deliberately protected the equipment accounts and did not force such an internal redistribution. Many of the medical centers, out of prudence, have wanted to wait until toward the end of the year to be sure that they were not going to be forced to use that money for other operations. But we have made special efforts to protect the equipment money this year, and I think that's an importation action, even though, as I said, the total amount of money available won't allow us to begin catching up on the backlog.

Mr. **Steinberg.** In the spending plan projection that you assisted me in asking you for, which we hope you will be able to get to us by the 14th of this month, a week from Friday, would you address what actions you are going to take specifically with respect to restoration of supplies and equipment in terms of directing your field facilities to prepare plans so that, when the money is available, it can be obligated as quickly as possible, and so that the delay that is attributable to orders and competitive procurement requirements in the case of some large items, can be minimized?

Dr. **Gronvall.** Yes. We work well in advance on those plans so that we are exactly ready and in a position to be able to obligate the funds once they are received. And so we will be able to speak to that.

Mr. **Steinberg.** That would be very helpful.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

The VHS&RA is currently developing plans for the expenditure of funds for restoration of supplies and equipment items should such funds become available in the final 2 fiscal year quarters. Medical center managers are being advised to manage extremely conservatively; to obligate funds only for items absolutely necessary and to not replenish shelf stock. This action is required to ensure adequate operating funds through the fiscal year should supplemental funding not become available or be received too late in the fiscal year to be used most effectively.

Medical center managers will continue to operate "right at the margin" throughout this fiscal year in an environment of great fiscal uncertainty until this situation changes. Regional Directors are working with local Medical Center Directors to develop a priority list of supplies and equipment which can be procured rapidly once funds are available. Priority is given to items which can be purchased from contract; however, if funds arrive too late, obviously those items which cannot be procured from contract sources will not be purchased due to the lead time required.

Mr. **Steinberg.** One point of clarification, at the very end of the white paper, item 5 speaks to the allocation within your spending plan of $52.5 million to the regions to be utilized specifically to support deficiencies in all other funding availability.

Does that mean that a pro rata share of $52.5 million is going to be given to each region, and then it will be up to the regions to, within the other funding shortages, redistribute that money among their facilities?

Dr. **Gronvall.** Yes. That part of the budget, of course, buys things like drugs, and medicine, and supplies, and so, out of the total $300 million supplemental, something like $52.5 million is available for that part of the budget. We allocate that by first a regional allocation, and, in turn, each region makes an allocation to each individual medical center.

Mr. **Steinberg.** So the breakdown among those categories, which I take it are the ones described in item 6, if I read correctly, will be left to each region and may vary among the regions?

Dr. **Gronvall.** Well, the money is provided to the medical center as a single account, as a generalization, and then they utilize it based on local need as to what kinds of medicine, drugs, supplies, et cetera, are most needed.

Mr. **Steinberg.** So that the decision that will be made at the regional level will be what will be the distribution of this versatile money to each center, but the region will not have the authority to direct the specific areas where those moneys will be spent?

Dr. **Gronvall.** Correct.

Mr. **Steinberg.** And am I correct in trying to understand this, that item 6 is merely a supplementation of item 5 in explaining——

Dr. **Gronvall.** In fact, it is an amplification of the kinds of items that fall into the so-called "all other" part of the budget.

Mr. **Steinberg.** And is it possible for you to get for us for the record the amount of the "all other" funding shortages that have been identified as described in item 6 that are not going to be met? That is, the $52.5 million will buy $52.5 million of material to reduce that shortage, but what is the total shortage? Do we know that?

Dr. **Gronvall.** I believe that we have a pretty good fix on that figure, and that can be supplied to you.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

For the fiscal year 1989 budget plan, facilities were assigned a Personal Services floor based upon their appropriate share of the total Personal Services floor mandated in the Appropriation Act. Accordingly, each facility budgeted for "All Other" after deducting the P/S floor from total available funds. This left what was recognized as an extremely large shortage in the "All Other" area in addition to the inability of the available P/S funds to support assigned FTE. Approximately $126 million was estimated to be short within the operating service and supplies categories which was necessary to provide the mandatory workload. This was identified in the following operating accounts.

Drugs and medicine	$57
Medical and dental supplies	34
Blood products	2
Operating supplies	12
M&R supplies	11
Prosthetics supplies	10
Total	126

The supplemental provided of $52.5 million will certainly be of assistance in meeting a portion of the anticipated deficit but will in no way eliminate the overall shortages in the operating accounts.

In addition to the above shortages, additional shortages are prevalent in areas such as dietetic provisions, beneficiary travel and other related travel accounts, communication costs and also other miscellaneous services such as NRM services and other contractual services.

Mr. STEINBERG. Do you have a ball park figure at this time?

Dr. GRONVALL. No, I don't, at least in my head.

Mr. STEINBERG. OK. What I would like now to do is to move away from this letter, and again, reiterate what a helpful letter it is, what a direct letter it is, what a responsive letter it is, and in making that statement, I don't wish to suggest that those adjectives are not always applicable to everything that the Department does, but that this was just particularly helpful.

Dr. GRONVALL. It is an indication, Mr. Steinberg, of what I said earlier, that we have tried to have our plans well developed, both on the basis of what we need and what we would do with the funds when we receive it. So even though we had less than 24 hours to prepare this, the staff work and thinking and planning had already been done, so we could crystallize it and put it together and supply it in short order.

Mr. STEINBERG. In fairness, so that we don't appear to be totally unreasonable, you were given more notice than 24 hours that these sorts of questions were going to be asked with a short response time—since we discussed it the preceding week—but the letter obviously did not reach the agency until about noon on Monday, and so that's when you officially received the letter.

Dr. GRONVALL. Absolutely. But in that broader context, the President has requested $303 million. We believe that when that request is put on the table someone should be able to ask us instantly, what are you going to be able to do if you get the money, and we always have that plan in hand and developed at the time the request is made, so would have prepared to respond quickly.

Mr. STEINBERG. John, one specific item that was addressed in Senator Cranston's April 3 letter that was not, I believe, responded to in detail, and perhaps we have missed it, was whether or not this would permit you to meet your special salary rate obligations. Is the answer to that "yes" and that that is covered in your overall salary response?

Dr. GRONVALL. Correct.

Mr. STEINBERG. Can you tell us how much additional funding would be needed in fiscal year 1990 now to maintain a 194,720 FTEE level and a balanced program?

Dr. GRONVALL. Yes. Again, we have previously been asked that question, and we supplied a detailed letter I believe back in February. The total figure that was in our previous response was, I believe, some $796 million above the level in the previous President's request for 1990. That is not an exact figure, but that's very close.

Mr. **Steinberg**. That's my recollection.

Dr. **Gronvall**. And we had supplied that raw figure and the backup to it.

Mr. **Steinberg**. Does your submission, which we will ask you to resupply so that we will print it in the record at this point, specify the assumptions underlying those additional amounts? My recollection is that it does not do so fully, and we are wondering if you might be able to amplify those assumptions when you resubmit it to us.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

The resources required in 1990 to maintain a balanced medical care program at an employment level of 194,720 FTEE is $11,538,285,000. This represents an increase of $796,854,000 over the 1990 Reagan budget request.

In developing 1990 resource requirements, the 1989 appropriation was used as the base. Funding was added to support 1989 supplemental requirements including a pay raise increase from 2 to 4.1 percent, special salary rates, Federal employee health benefits, AIDS/universal precautions and the provisions of Public Law 100-322. Uncontrollable 1990 current service items such as payroll, inflation, and facility activations have also been added. Program and management initiatives in the 1990 Reagan budget have been included with the exception of the redistribution of levels of care (workload adjustment) and the procurement savings initiatives. These resources would support additional workload as follows:

	1990 Reagan budget	1990 revised projection	Change
VA hospital patients treated	1,078,993	1,099,877	+20,884
Outpatient staff visits (000)	21,277	22,956	+1,679
VA domiciliary patients treated	12,249	19,669	+7,420
Community nursing census	7,260	11,580	+4,320

Dr. **Gronvall**. The basic assumption of the letter really had been stated to us, I believe, primarily by Chairman Montgomery, namely, to operate our hospital and health care system at a level of 194,720 total staffing, and have appropriate amounts of money in the other accounts, drugs, medicine, equipment, et cetera, so that a balanced program would be operated, what would the total figure be that would be necessary. And it was on that assumption that we responded to the letter.

Mr. **Steinberg**. And does that include, then, a projection of inpatients and outpatient treatments, et cetera, that would be obtainable under that increased funding?

Dr. **Gronvall**. Yes.

Mr. **Steinberg**. If your funding is delayed until July 1, will you have to reformulate your spending plan?

Dr. **Gronvall**. For this year?

Mr. **Steinberg**. Yes. Or I think that may be part of the response that you will be giving.

Dr. **Gronvall**. Yes, but the response will give you, I think will describe—and these are very hard letters to write, to take all of the possible contingencies in account. But, as a generalization, yes, and we do make those plans, and as the clock ticks along week by week, we have to adjust them and update them, of course.

Mr. Steinberg. And it's clear that you are committed to doing everything you possibly can to getting the maximum benefit out of this supplemental request, including whatever actions can be taken in anticipation of receipt of it?

Dr. Gronvall. Yes. My approach to that is very easy. I am willing to take all possible risks and steps that we can to continue operating our hospital system on the assumption that we will get the supplemental that has now been requested, and continue operating just to the exact point where the next action that we would take would end up with somebody, namely, probably me, going to jail if something happened and we didn't get the supplemental. We operate under the very tight constraint, of course, of the Federal Financial Managers Integrity Act, or the Anti-Deficiency Act, I've forgotten the name of that law, but we have no ability to obligate funds we don't have. So internal juggling, borrowing, reprogramming, et cetera, is fine, but I depend on sophisticated staff people to tell me when, the day or point at which we would have run out of gas on those actions and be forced at that point, then, to begin decreasing our staff, decreasing our commitments to end the year in balance if, God forbid, we did not get a supplemental.

Mr. Steinberg. I think Dr. Lewis, at our budget hearing, testified that the actions that would have to be taken would be very dire ones, indeed, at that point.

Dr. Gronvall. Absolutely. I mentioned earlier we are now operating at a level of 191,200 staff. If we do not have a supplemental, we would have to end the year at 186,000 staff, so we would have to get down between now and then from 191 to 186. That is a very major reduction, and we would have to put essentially every other obligation on hold in order to stay within the appropriation that we do now have.

Mr. Steinberg. Just very roughly, in order to come down 5,200 in one quarter, you actually have to reduce staffing by about four times that amount.

Dr. Gronvall. That projection to get down to 186 would be a staffing level at the end of the year. That is not a cumulative FTEE figure.

Mr. Steinberg. And 5,200 in one quarter is a lot?

Dr. Gronvall. Yes.

Mr. Steinberg. We heard this morning in the testimony, and you were with us for that, that the funding shortfall is having differential impact across the system.

Can you explain why this should be happening, and also indicate if you think there is some way to equalize the impact, and if that should be done?

Dr. Gronvall. Yes. I will try to give a brief comment to that. Over the past years, year by year, as veterans and veteran population redistributed itself in the country, it became increasingly apparent to us that the relative capacity of our VA system to provide care relative to the demand differed across the country.

At the beginning of this year, we felt so concerned about that that we established a 3-year objective under the banner of geographic equity of access, and took the first set of actions this year to distribute our funding allocations region by region. This was the first step in a 3-year plan to try to redistribute our funding so that, at the end of that time, delivery capacity would more closely match veteran demand for care throughout the country.

Part of the reason that that issue has been forced in on us most recently is the new prioritization statute that establishes category A, B, and C veterans. Prior to that time, we didn't have that refinement of eligibility criteria.

So, given a budget shortfall, we have taken the step, of course, to constrain or virtually eliminate category B and C care. As I said, some parts of the country had a capacity that had been built up over the years that would have allowed them, if they had adequate funding, to provide a considerably greater amount of B and C care than other parts of the country.

It is for that reason, that historic set of factors that created a mismatch between demand and capacity, and then the beginning readjustment of that across the country, that the impact of this budget shortfall falls unequally on different parts of the country. Obviously, beyond that, each individual medical center at a very fine level of management is in a somewhat different position. There are local factors, such as sharing agreements, the availability of another medical center or clinic close by, working relationships would be over these facilities, thousands of detailed factors that, at the local level, impact to either ameliorate or worsen a budget shortfall. Availability of staff, local salary levels, all of those things have very remarkable different geographic impact.

One of the things that impresses me as I both travel around the country and come to a hearing like this and listen to our field witnesses is the ability of each medical center to portray with great force the unique factors that negatively impact them, and then the next medical center has a different set of unique factors. I recall having heard someone say once that budgeting is the process of uniform distribution of dissatisfaction. We try to take all of those factors into account, but each medical center really does operate with a unique set of local problems and they are not all exactly equivalent in terms of dealing with a funding shortfall as a result of that.

Mr. STEINBERG. And you are generally satisfied that what has transpired is more or less in line with what you anticipated would transpire?

Dr. GRONVALL. I really am. As I have tried to look across the system, it appears to me that every one of our medical centers is hurting this year, and, as I have heard, individual directors, individual chiefs of staff, comment on what they have had to do, and as I have read the reports about the extent to which each has cut back or had to close beds or close programs, it appears to me that we really have distributed the problem widely, I wouldn't claim with exact equity to every medical center, but I surely do not have the sense that any of our medical centers is just cruising along, not feeling the problem, while others are having serious problems. Everyone this year, I think, is having a significant problem of roughly the same dimension.

Mr. STEINBERG. At the outset of the year, you gave individual facilities a great deal of flexibility to decide how they were going to respond to funding shortfalls.

Are you satisfied with the results of that approach?

Dr. GRONVALL. As a general way, I surely am. But it depends on what the measure of success is. From my standpoint, the measure of success is to get the greatest overall amount of care of veterans for the money that we have. I am very convinced that decentralized authority for decisionmaking achieves that objective. I could relay anecdotes where, at a given district, let's say there are four or five hospitals that work closely together so that when one hospital closes some beds in a nursing home care program, another hospital closes some beds of its surgery program, a third hospital takes a different action. We have been criticized this year by external observers who say it's obvious that there is not a strategic plan operating because this hospital is taking one kind of action, the hospital down the road is taking a different action, so it appears that nobody knows what is going on.

I believe the reasons why those different kinds of actions are being taken is exactly what I have said, that at a district, and local, and regional level, our medical centers are working together more in collaboration now than I have ever seen them, so that when one hospital takes an action they try to do it in concert with different actions at other medical centers. So I am very proud of the multiple sets of actions taken.

The other side of that, as I said, depends on what the measure of success is. If the measure of success is the ability of someone, like me, to say precisely at some point in time, "Here's exactly what we'll do, every medical center will do it," and then carry that out, we could have dealt with this shortfall that way. It would have meant cutting much more deeply into the actual care of veterans to enact and promulgate from Washington a very detailed set of operating instructions to every individual medical center as to exactly what they should cut back and what they shouldn't cut back.

I think the quality of care and the amount of care we have been able to deliver would have suffered by that management approach, but there are some people who would have felt that that was better management because it was being all rigorously and rigidly centrally directed.

So, again, it depends on what the objective is of how best to manage in a shortfall, and on my terms, I believe that giving flexibility for intelligent local decisionmaking is the best way to continue getting the best amount of quality veterans care for the dollar that we have. It has to be always done within a set of national policies, and we adopted a set of national policies last year that provided a framework within. Decentralized decisionmaking went on and provided priorities for our medical centers.

Mr. STEINBERG. It is fair to say that that degree of discretion that was provided at the outset of the fiscal year is no longer there if we understand what Secretary Derwinski advised Senator Cranston of in his March 20 letter that he had directed you to do on March 3, and that is that all VAMC policy changes with the potential of impact on access to nonemergent care should not be implemented until approved by the Secretary.

So is it correct to say that that discretion no longer resides in the field to the same extent it did?

Dr. GRONVALL. Correct, but let me just expand a little on that. Going back to the first of the year, and coming up into March, across the system we—and by "we" I mean our medical centers, our regional directors, and we in Washington—had taken some 400 specific individual actions about medical center beds, medical center programs, other medical center actions, as a way of dealing with the funding shortfall.

In early March, Mr. Derwinski asked us to put a hold on any further actions that would have the effect of reducing access to care until he could review with us the rationale for taking those actions, the need for action, and, in the context of the impending request for a supplemental, which at that point had not been made. We have had followup reviews with the Secretary and with the Deputy Secretary about the actions that we have pending for further program changes, bed closures, et cetera, in the context of our projection now for the supplemental funds which have been requested by the President. I believe that, within the next few days or a week or two, we will have completed that review and will be again taking specific actions at medical centers, necessitated by whatever the budget status is at that point.

In that context, I think the Secretary wished very much to get deeply into the matter to ensure again that we are taking the most intelligent possible actions across the system in a difficult year, and tailoring those also to our expectation of what we will be able to do with supplemental funding.

Mr. **Steinberg**. In that March 20 letter, Secretary Derwinski also said that, "Decisions regarding the closure or reduction of substance abuse programs will no longer be at the discretion of the individual medical centers."

Does that mean, as it seems to mean, that any efforts to bleed off resources from those programs at the individual medical center level will not be permissible?

Dr. **Gronvall**. Correct.

Mr. **Steinberg**. You heard the testimony of our prior panel about what they felt was a very serious erosion of morale in the field among your health care staff, and the effect that that has, and that the general funding situation has, on recruitment and retention.

Would you like to comment on either or both of those issues?

Dr. **Gronvall**. I think that you heard quite uniform and widespread testimony from the people who are on the firing line in our hospitals, and I have no information that would lead me to a different conclusion than you heard described here.

Mr. **Steinberg**. And you share the concerns they express?

Dr. **Gronvall**. Absolutely. I have visited a number of hospitals, and when I walk around in a hospital, I would say generally the people I stop and talk to are enthusiastic about what they are doing, enjoy the opportunity to talk to me. But that's an artificial situation when I'm coming walking through a hospital, and so wherever I go and talk individually and independently to directors, chiefs of staff, service chiefs, et cetera, I hear the same kind of comments that were heard here in testimony, and I share those views and believe that was a valid summary of the situation.

Mr. **Steinberg**. You also heard the discussion about the impact of the funding shortfall on quality of care.

Do you share that concern, and what comment might you have on that issue?

Dr. **Gronvall**. Very clear that care is being delayed, so timeliness is suffered. We have tried to make sure that where there was a delay in providing care, a physician had made the judgment that the delay was, in fact, an acceptable delay where we were going to provide the care. That's easier to say than to do in every case when you are dealing with thousands of patients across the system. It is certainly clear that there will be many instances where we evaluate a patient, conclude that the veteran needs medical care that can be scheduled, but because the veteran is category B or C, we can't provide it, and so we try to help them find some other place. And I am sure that some significant number of those veterans will end up not going somewhere else, and therefore not getting care, and that surely is an erosion of the quality of care for those veterans.

Mr. **Steinberg**. And also perhaps, coming back to your system with emergency problems that would have otherwise been avoided?

Dr. **Gronvall**. Of course. So I share all of those concerns. Dr. Threefoot made a very strong comment that there are no, as yet, useful quantitative factors to come to grips with quality of care in a way that is really documentable and useful across a large system of hospitals, or even a whole hospital. So that is frustrating in terms of really responding in any kind of quantitative way to the question, what's happening in quality of care.

Mr. **Steinberg**. It is not frustrating that he made the statement, but it's frustrating that the statement is correct?

Dr. **Gronvall**. It is the fact that there is no such yardstick is extremely frustrating, and we have grappled with that and the Health Care Financing Administration has spent millions of dollars attempting to encourage people to come up with yardsticks for quality of care. Every time I enquire about that, I am told that we are maybe about 5 or 6 months away from having one that might be useful, and that just kind of keeps slipping on into the future. But many people are working on that, and I think that we will be able to come up with some yardsticks that are more useful.

Mr. **Steinberg**. Indeed, I believe that Senator Cranston wrote you a letter recently about a joint private sector effort that is under way to try to develop such increases. That effort, I believe involves collaboration by the AHA and the AMA, et cetera, and Senator Cranston asked what activities you might be taking in conjunction with that effort.

Dr. **Gronvall**. Yes. We are preparing a response to that. In short, however, we have been asked to be a part of that effort, so the VA will be a formal participant with that group of hospitals working on the issue of documentation of quality of care.

Mr. **Steinberg**. Let me say at this point, we will print in the record at this point that letter that I just referred to, and your response to it, please.

[The letter and response appears on p. 140.]

Dr. **Gronvall**. Another comment might be useful here. There was testimony earlier about the resource allocation model, and Senator Cohen asked the question about incorporation of quality of care into that model.

Last fall, when we made some decisions about changing our allocation model, because we were moving to a different management system this year in terms of work load management, one of the objectives that we put formally in writing was the objective to find a way to incorporate quality of care as a factor in our process for budget allocations. When we did that, everyone applauded, but so far we haven't been able to come up with a satisfactory quantitative way to do that in a very large and complicated system of allocating the budget that we get. But we have adopted that as a formal statement of objective in trying to come up with a way to take quality of care factors into account in allocating our funds.

Mr. STEINBERG. Have you not taken action with respect to suspending the RAM?

Dr. GRONVALL. Yes. And I was somewhat surprised by earlier testimony saying that a medical center with a reduced work load is in a catch 22 because they will be subsequently penalized, through the resource allocation model, for that. That is not the case, because we have explicitly stated that this year we have adopted a work load management strategy where we have come to agreement with each medical center about how much medical care they can deliver on the basis of quality within the budget allocation they have gotten. And if that work load is lower, higher, whatever, compared to last year, they will not be penalized in subsequent budget allocations for that.

In short, we have terminated the open-ended financial incentive that previously existed in the resource allocation model that was leading medical centers to seek ways to just continually expand the volume of care they were giving in the hopes that they would subsequently get financially rewarded.

Mr. STEINBERG. For the appearance of doing something?

Dr. GRONVALL. Yes. So we have explicitly terminated that.

Mr. STEINBERG. Is that for this fiscal year and the next?

Dr. GRONVALL. Yes. The details of what total set of factors we will use following that for making the detailed allocations hasn't been completely worked out yet, but we have announced that that incentive, based only on quantity of care, has been terminated as a factor in our allocation process.

Mr. STEINBERG. But does that mean that all the rest of the RAM stays in existence except for that factor, or that the whole RAM is suspended for fiscal years 1989 and 1990?

Dr. GRONVALL. We have not suspended the whole RAM, because the resource allocation system is a process that utilizes all kinds of information in taking a congressional appropriation and ending up allocating it to 172 hospitals. So we have to have a system for doing that.

The DRG system and the other models that we have developed remain as the most credible mechanism we have for documenting the amount of medical care given at each medical center. So, as a work load quantity yardstick, that part of the system remains a useful management tool.

Mr. STEINBERG. That is not an allocation methodology?

Dr. GRONVALL. Correct. That's just a work load measurement system, not an allocation methodology.

Mr. STEINBERG. So it is fair to say that the facilities do not now know how allocations will be made of the supplemental money for fiscal year 1989 and of the station allowances for 1990?

Dr. GRONVALL. They don't know the full details of that. We have budget meetings in July with each of our medical centers to review the work that will have been done to that point on the process to allocate the fiscal year 1990 appropriation. So that work is in process.

Mr. STEINBERG. One of the purposes of the RAM was to try to provide some stable guidelines with predictability and concurrently to create certain incentives for certain actions to be taken.

Is it fair to say that those goals no longer will be your goals in the allocation process, since you certainly are not going to be able to influence behavior except to say that the previous incentive is no longer there?

Dr. GRONVALL. Correct. And I don't feel that it is appropriate to say that that previous incentive was inappropriate.

Mr. STEINBERG. Please, I did not say that.

Dr. GRONVALL. Correct. I just wanted to amplify that. I was a part of that process, supported it, and I think it was useful in its time and in its place. It created a powerful incentive at our medical centers to concentrate on finding ways to provide as much medical care as possible, and I think it was a powerful stimulus to shortening length of stay, taking some other steps that had been highly appropriate. Unfortunately, what happened is exactly what was testified here earlier. When the total amount of money becomes inadequate, having an open-ended incentive to expand work load, hoping that someday you will get funded for it, becomes disfunctional, and so that was why we disconnected that part of the system.

Mr. STEINBERG. I hadn't intended to say anything more about the RAM, but you have stimulated me.

At the time that you adopted the RAM, the budget was inadequate to create those incentives.

Dr. GRONVALL. I think that is true, but the budget shortfall was relatively less of a crunch then, and there was, I think, a lot of evidence that the VA—and this is like 6, 7, 8, 9 years ago—that the VA was not putting enough effort on getting the greatest amount of medical care possible in its facilities and with its resources. The length of stay was much longer then than it is now, and there were some other indicators I think that led the VA officials at that time—this was not me—to rightly conclude that creating an incentive to increase the amount of care we were delivering would be an appropriate thing to do. And, on its record, I think that was a success story.

Mr. STEINBERG. It was. My comment is directed at the returns that we got from the field after the RAM was put into effect, stating, "My reward was that I wasn't cut." And that is sort of like rewarding your child for good behavior by not spanking him.

Dr. GRONVALL. Since every year in the past decade, our actual appropriation increase has been below the medical care inflation cost of providing care. We have truly never been in the position to reward anything across the whole system with a true increase in new purchasing power.

Mr. STEINBERG. You know exactly what I am going to say next, because every time you refer to that I say, "And what would it have been like if Congress had not added the $1.6 billion to those requests over the last 7 fiscal years?" And now you can make the response that you always make when I always say that.

Dr. GRONVALL. It would have been very much worse than it is, than it was.

Mr. STEINBERG. Thank you, John.

One more word on quality of care. You have a major effort under way, I believe, a task force that is making recommendations to you on how to go about reorganizing your quality assurance program in the veterans services, health services and research——

Dr. GRONVALL. VHS&RA. If you practice it a couple hours a day, it starts to roll very easily, VHS&RA.

Mr. STEINBERG. In your administration, could you tell us what your schedule is for receiving that task force report and then moving forward to make decisions?

Dr. GRONVALL. We received the first report of the task force, and after review, I asked the task force to respond to a suggestion of making some changes in part of that recommendation. I believe it was about a week and a half ago the task force did respond to that review, and so their first report plus that additional set of comments are now being put together as an action recommendation to me, which I expect to receive within a week or two and take action on, because I have reviewed what has been recommended.

At that point we then will turn back to the task force for some additional help together with our management staff in Washington to design the steps necessary to get from where we are now to the recommended changes in our quality assurance organization and program function.

Mr. STEINBERG. Does that suggest that you expect to make your preliminary decisions by the end of this month?

Dr. GRONVALL. Yes.

Mr. STEINBERG. And at what point will you turn to the designation of an individual as a permanent full-time quality assurance head?

Dr. GRONVALL. That will be part of the implementation of the actions that we are about to endorse.

Mr. STEINBERG. But that might occur following the decisions you will take prior to the end of the month?

Dr. GRONVALL. Yes. Senator Cranston had asked earlier about the status of the recommendations in the report, and we said that as soon as they were acted upon, we would supply that information, and we will do so.

Mr. STEINBERG. So we might expect something by the end of the month?

Dr. GRONVALL. Yes.

Mr. STEINBERG. And you will make sure you provide that concurrently to our minority?

Dr. GRONVALL. Yes.

Mr. STEINBERG. There were two cases that were particularly poignant, we thought, that were testified about this morning by the PVA witness, Richard Woodworth, and we would like to ask you to personally look into those two cases.

One involved a PVA member by the name of Billy Kraft, who, because he was unable to be admitted to the Memphis VAMC, where they have an SCI unit and substantial expertise in SCI surgery, had to receive a major surgical procedure at the Jackson, MS, medical center, which does not have that experience and does not have that SCI unit, and the results described were very unfortunate, and in material which I believe has already been submitted to your office, there is included various policy statements which are described as being about to be implemented in the Department that would appear to prohibit that sort of surgery from occurring at a facility without substantial SCI surgical expertise.

And we would ask you to look into that matter and get back to us about it, personally, please, and also to do what you can and to tell us about that, to expedite the issuance of that policy guidance which the PVA has stated is about to be issued.

Dr. **Gronvall.** I will surely be pleased to.

[The information furnished is retained in the committee files.]

Mr. **Steinberg.** The second case involved, according to the PVA, the use of a orand of catheters which was being selected, it is alleged, because it was less expensive, and which, it is alleged by the PVA and its witness, creates significant dangers for veterans who must rely on it.

That information will be provided directly to you. It involves a particular case as an example, as an illustration as well, and we would appreciate you personally looking into that, advising us of your views on what transpired and also of what policy guidance you can issue to deal with that, if any is appropriate.

Dr. **Gronvall.** We surely will do that.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

For the past 15 or more years, the Hines Depot provided Foley catheters manufacatured by Bard. Recently, the Depot began supplying catheters manufactured by several other companies. The new catheters should be equivalent to those previously supplied; however, some patients have complained that the new catheters increased their bladder spasms and the connectors sometimes fall off. Our clinical staff is working with patients and evaluating these complaints and will thoroughly document any complaints which are substantiated. The documentation will be presented to Acquisition and Materiel Management Service to forward to the appropriate Central Office officials.

Mr. **Steinberg.** We have a series of questions about what has been going on this fiscal year, and I do not know the extent to which you can answer these questions today, or will have to do so for the record, or whether you indeed have the data available to do so for the record. But I will proceed to ask and see what answers we get.

Can you tell us how many VA facilities are doing the following: Turning away all category B and C veterans for inpatient care?

Dr. **Gronvall.** I don't have that detail at my fingertip. I would have to respond for the record.

Mr. **Steinberg.** Do you have the capacity to answer that?

Dr. **Gronvall.** Yes.

Mr. **Steinberg.** I will just briefly, then, read these and will provide them to you in writing, just to indicate the sorts of concerns we have.

The same information about outpatient care.

The same information about those that are turning only category C away for inpatient care, only category C away for outpatient care.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

Medical centers are following congressionally established priorities and sound medical practice in curtailing discretionary workload. Emergent patients receive care regardless of what category they fit into including categories B and C. Seventy-five medical centers have reduced inpatient discretionary workload and 77 medical centers have reduced outpatient discretionary workload through March 3, 1989. Discretionary workload is primarily category B and C veterans.

Mr. **Steinberg**. Do you have the information today to tell us how many medical centers have been forced to close down beds as a result of the funding shortfall?

Dr. **Gronvall**. 26 percent of our medical centers have closed beds during this operating year.

Mr. **Steinberg**. Do you know how many beds that is?

Dr. **Gronvall**. Yes. That is, out of a total number of acute care beds that were in operation at the beginning of the year of 71,570, 1,823, or 3 percent, of those operating beds have been closed in the one-quarter of our medical centers that have taken specific action to close beds.

Mr. **Steinberg**. As a result of the funding shortfall?

Dr. **Gronvall**. Correct. Yes, there are other beds closed, of course, for construction projects, renovations, et cetera, et cetera, but this is related to funding shortfall.

Mr. **Steinberg**. And what number of your facilities have closed down or reduced particular programs?

Dr. **Gronvall**. About 44 percent of our medical centers have taken some specific action either to close a program, close beds, or take a defined action of that sort to restrain their operation.

Mr. **Steinberg**. Would you be able to break that down as to closing or reducing programs for us?

Dr. **Gronvall**. Yes.

Mr. **Steinberg**. Not right at this moment, but for the record.

Dr. **Gronvall**. Yes, I believe we can.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

A total of 108 medical centers have reduced workload in some manner. Forty-three VA medical centers have closed beds due to funding with a total of 1,905 beds closed. Of those, 218 are nursing home care beds and 1,687 are acute beds divided as follows: 460 medicine beds, 404 surgery beds, 271 psychiatry beds, 246 substance abuse beds, 242 intermediate medicine beds, 42 rehabilitation beds, and 22 neurology. The total estimate of fewer inpatients treated for fiscal year 1989, reported to date, is 19,275 distributed among 75 medical centers. In addition to inpatient workload changes, with the actions taken to date, there is an estimated fiscal year 1989 reduction of 545,914 outpatient visits distributed among 77 medical centers and an estimated reduced community nursing home care census of 893.5 distributed among 41 medical centers.

Mr. **Steinberg**. And do you know the number of VA nursing home beds which have been closed, nationwide, for budgetary reasons?

Dr. **Gronvall**. Yes. At the beginning of the year, we had some 12,363 nursing home beds in operation. We have to date closed 198 of those, so that is about 2 percent of the nursing home beds that were in operation at the beginning of the year.

Mr. **Steinberg**. And what action will be taken to reopen those beds or the 1,800 hospital beds, assuming enactment of the supplemental?

Dr. **Gronvall**. As a generalization, if we get the supplemental as requested, it will make essentially no difference in the beds that are closed.

Mr. **Steinberg**. They will stay closed?

Dr. **Gronvall**. It will stabilize our operation about at its level, but not allow us to reopen closed beds in hospitals or nursing homes.

Mr. **Steinberg**. Could you give us the dollar figure that you would need in fiscal year 1989 and the dollar figure that you would need in fiscal year 1990 to reopen those closed nursing home beds and those closed acute care hospital beds?

Dr. **Gronvall**. Yes. The 1989 figure would be a much harder one to get, because again, it has to do with the timing at the end of the year. But we can supply that figure for 1990 and make some comments about how we could phase up toward that during the end of 1989.

Mr. **Steinberg**. The $796 million or so that you referred to would not, or would it, permit the opening of all of those hospital and nursing home beds?

Dr. **Gronvall**. As a generalization, that figure would include the staff and other support necessary for us to be back at the level of operation we were at at the beginning of this year. So it would include resources to have those beds back in operation.

I make that statement as a generalization, not a precise comment about some specific exact bed figure.

Mr. **Steinberg**. Do you have data that describes how many programs, nationwide, individual programs such as nursing homes, hospital based home care, substance abuse, ICUs, CCUs, et cetera, have been closed or reduced?

Dr. **Gronvall**. Yes. As I mentioned earlier, we had taken some 400 specific actions to either close beds, reduce programs, close a program, that would be reflected in a reduced work load, and we, of course, have the documentation about each of those actions.

Mr. **Steinberg**. So that those could be broken down by category for us for the record?

Dr. **Gronvall**. Yes.

Mr. **Steinberg**. That would be very helpful.

Does that also describe where they are?

Dr. **Gronvall**. Yes.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

The information collected is generally not in the detail specified for individual programs. Data is available by program for substance abuse and nursing home.

The following is a list of substance abuse programs which have sustained either closures or reductions in capacity.

Closed—Medical Center:	*Number of beds*
Biloxi	44
Buffalo	17
Ft. Lyon	28
Manchester	14
Newington	10
Providence	30

Sepulveda	30
White River Junction	16
Reduced—Medical Center:	
Atlanta	18
Hines	30
Togus	10
Total beds closed	257

The following is a list of nursing home care beds which have been closed:

Medical Center:	*Number of beds*
Ann Arbor	20
Cincinnati	26
Gainesville	30
Livermore	10
San Diego	30
Seattle	30
Sepulveda	42
Syracuse	30
Total beds closed	218

Mr. Steinberg. Do you know how many medical centers had this fiscal year stopped providing nonprescription drugs until you reversed that policy after Senator Cranston's strong urging at the budget hearing on March 13?

Dr. Gronvall. I believe we know that.

Mr. Steinberg. That is, your reversal of the policies on March 13. The budget hearing was not on March 13.

Dr. Gronvall. I believe we know the answer to that, but I am not positive that we have detailed information.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

Medication formularies for VA medical centers are managed locally. Thus, central tracking of drug deletions and additions to VAMC formularies is not conducted. A survey of all VA medical centers conducted through the regions in early March 1989 identified a small number of VAMCs who had deleted over-the-counter drug products from their formularies.

Mr. Steinberg. In connection with that policy—and you and I have discussed this—is it your intention that the provision of nonprescription drugs and the types of nonprescription drugs which are being provided, and the veterans to whom they are being provided, is to return to the policy that each medical center was following prior to the beginning of this fiscal year?

Dr. Gronvall. Yes. And that has been an important deliberation, but I think we have come down finally on the side of saying that the most important decision we make about an individual veteran is whether or not we can undertake the veteran's care, and if we undertake the veteran's care, then we provide the full care that is necessary. So, that has been the basis for reversal of some previous policy positions that we had adopted this year.

I should just add that, to implement that policy in a global way, means that if we expand the care given to the veterans we are caring for, assuming the total budget is fixed, some additional number of veterans would not be cared for as a tradeoff.

Mr. Steinberg. Despite the hot line call made on that policy change, and the TWX that was subsequently sent on it, we continue to receive reports that the message has not been fully received or understood, including reports since then about the situation at

White River Junction. I know you have a letter from Senator Leahy and Senator Jeffords on that issue.

Would you consider, please, reiterating to your field facilities exactly what you have stated here, that the policy that is to apply is to return to the pre-1989 policy and that any items which were withdrawn from the formulary this fiscal year which were previously in the formulary of that particular medical center, are to be supplied as they were prior to this fiscal year?

Dr. GRONVALL. You have made a very sweeping and very precise request. I think what I need to do is confer with Dr. Winship because I believe we have taken steps that are consistent with what you have just described. If there is ambiguity about that, we will certainly reinforce the message, and if we need to get back to you to clarify what we have or haven't said, and whether it is consistent with what you just said, I would like to do that.

Again, those are very precise kinds of directives that we have given to our medical centers.

Mr. STEINBERG. My understanding is that the last written directive that you have issued referred to providing all items on the medical centers' formulary, but did not address the question that items may have been removed from the formulary in the course of this fiscal year, and what the obligation of the medical center may or may not be with respect to restoring such items to the formulary.

Dr. GRONVALL. I can't speak, of my own knowledge, to whether we specifically addressed that or not. I think we will just have to get back to you on that.

Mr. STEINBERG. And also get back to us as to what clarification you may be issuing. Thank you.

Dr. GRONVALL. OK.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

The Veterans Health Services and Research Administration restated existing policy to all VA medical centers regarding the provision of over-the-counter (OTC) pharmaceuticals on the March 10, 1989 National Director's Conference Call. This action was also transmitted by teletype to all field stations on March 14, 1989. The policy states that all pharmaceuticals and medical supplies determined to be medically necessary will be provided veterans treated by the VA.

Mr. STEINBERG. With respect to community nursing home care, that was addressed in the Secretary's letter, and it seems quite clear from that as we read it that you are restoring approximately $3.27 million to that program, which will support an increase in the average daily census from where it is now, but not a restoration in full of the average daily census projected at the beginning of the fiscal year.

Is that correct?

Dr. GRONVALL. Yes.

Mr. STEINBERG. Do you know what the shortfall is from the beginning of the fiscal year?

Dr. GRONVALL. We started the year with a plan, as that white paper points out, to have some 10,709 average daily census. That has declined significantly now. We will put these additional funds into build back up, but I don't believe we will get fully back to that level. I think we would have to follow up with more specific information, and again, the timing of when we get the supplemental will influence what we will be able to achieve.

Mr. STEINBERG. Somewhere between 9,800 and 10,709?

Dr. GRONVALL. Yes.

Mr. STEINBERG. But if you can give us whatever your estimate would be, based on perhaps your April effective date and then maybe your July 1 effective date, as two bench marks, that would be helpful.

Dr. GRONVALL. OK.

Mr. STEINBERG. Do you know how many VA facilities have, this fiscal year, reduced the lengths of stay that they are providing under contracted community nursing home care, which had generally been, of course, 6 months? Do you know how many centers have made that shorter?

Dr. GRONVALL. I don't know, but I believe we have that information and could supply it.

Mr. STEINBERG. And also, if you could provide us with, as far as you know, what is the shortest period that any medical center is utilizing, and I believe we have heard as short as 60 days, and what is the current average period in the system. Do you think you know that?

Dr. GRONVALL. I will not promise that we do, but if we have the information available we will supply it, and if not, we will make whatever information we can available.

Mr. STEINBERG. Do you think you have available how much money was freed up to be used for other purposes by these restrictions on community nursing home care?

Dr. GRONVALL. We can supply that, I believe, on a basically calculated basis of comparing census to the average cost of the care.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

The current best estimate for the Community Nursing Home Care program in 1989 is for a workload level of 9,713 ADC which will cost $267.1 million. This is a savings of $25 million from the $292.1 million identified in the middle column of the 1990 President's budget.

Presuming an April 1 supplemental, an additional 871 ADC could be supported and all $23,770,000 would be obligated. This would generate an annual program level of 10,584 ADC, with the monthly census reaching 12,250 in the last 2 months.

Presuming a July 1 supplemental, an additional 183 ADC could be supported for a total ADC of 9,896. This would require $4,994,000 of the $23,770,000 in the supplemental request. Monthly census would reach a level of 10,750 in September.

The average length of stay (LOS) in the Community Nursing Home Care program was 140 days in September 1988 and 143 days in January 1989, the latest available data. Nationwide, LOS has remained fairly constant over the past decade. Information of LOS by VA medical center for fiscal year 1989 will not be available until later this summer.

Mr. STEINBERG. With respect to beneficiary travel, do you know how many medical centers have restricted payments for beneficiary travel this year?

Dr. GRONVALL. All of the medical centers are operating under a specific mandate that was expanded in Public Law 100-322.

Mr. STEINBERG. We know they are operating under it.

It doesn't seem that they are operating in accordance with it, however.

Dr. GRONVALL. Well, the fact is that the actual expenditures we have made have lagged behind what we had projected that would cost. As I have visited medical centers, I have asked why that is, and I have gotten two different reasons, two reasons at least. One is that the veteran service organizations, led particularly by Disabled American Veterans, stepped in with a very vigorous volunteer system of transportation. Even beyond the vans that they have donated, that has stimulated car pools, et cetera. A good part of the need of beneficiary travel has been met on that volunteer basis. And then second, veterans whose past experience was that that benefit was decreased, may not have always had the word that it had become available again, and so some of them, or many of them have not applied for the funding. And those two reasons, plus, I suppose, a lot of other individual local reasons explain why we are not spending as much money as we had earlier planned.

Mr. STEINBERG. Well, there is a third reason—I don't imagine you were being told about that reason—but Senator Cranston has written you a letter about that reason, which is that certain medical centers have established policies whereby they are providing beneficiary travel only in very restricted categories of cases, which policies, although they are under that public law, do not seem to be in accordance with it.

Dr. GRONVALL. I am unaware of any instance where that has occurred, but I wouldn't be amazed, I guess, to find one here or there in some odd corner of the country. And whenever we are asked about that, we look into it and that serves as one of the ways of reinforcing the general rules and policies that exist across our whole system.

Mr. STEINBERG. I believe you have advised us that you are looking into that matter in connection with that inquiry that Senator Cranston sent you, so we shall leave it at that.

For the record, if you could provide it for us, and we will submit this question to you in writing—with respect to what would happen in a whole variety of areas, inpatient-outpatient care, closed beds, reduced programs, nonprescription drugs, community nursing care, beneficiary travel, et cetera, if the 1990 appropriation is no greater than that requested in the Reagan budget request. We will submit that in writing.

Dr. GRONVALL. All right.

Mr. STEINBERG. We received in connection with this hearing, John, a report of The American Legion surveys of each one of your facilities, as well as testimony from The American Legion about that report. We will submit that to you and ask that you give us comments on the views expressed and the accuracy of the data in both the testimony and the survey, if you would, please.

Dr. GRONVALL. Surely, we would be pleased to do that, but I don't want to miss the chance to say that several of the service organizations regularly conduct visits of our medical centers. They are very good about sending us copies of those reports and asking us to comment on them, and I always say to the veterans' organizations that they serve as an extension of my own eyes and ears through that kind of survey and visitation and reporting. So that is helpful to us.

[The American Legion statement and survey appear on p. 154.]

Mr. STEINBERG. I am sure, in light of that, that you will find the Legion's material very valuable and interesting.

With respect to equipment, do you maintain a list, systemwide, that is broken down by the critical nature of the types of equipment that is in the backlog, and by the cost of that category of critical equipment that could be provided to us?

Dr. **Gronvall**. Well, we surely have detailed information about the categories of equipment in the backlog. I can't, of personal knowledge, speak to the headings within, you know, of subdivisions within that list. But the kinds of equipment, cost of it, and the status of the current equipment that is obsolete, needs to be replaced, or where there needs to be acquisition of new technology that wasn't available when the previous equipment was purchased, all of that we have in great detail.

Mr. **Steinberg**. Is it prioritized in terms of the critical nature?

Dr. **Gronvall**. Yes.

Mr. **Steinberg**. In terms of time?

Dr. **Gronvall**. Yes.

Mr. **Steinberg**. If you could provide that to us, and if, in so categorizing it, there are dollar figures that could be put in, for the most critically needed, for example, equipment within the $500 million—such as $130 million would go to the most important—something like that is what we would like to see if it exists.

Dr. **Gronvall**. I want to add a comment to that issue, because in the past, I have been dismayed to find that, because there were minor disagreements about some of the figures, between us and the Inspector General, for example, we would find ourselves in a position where someone would say to us, "Well, you say your backlog is $560 million, but someone else says it is only $542 million, so this year you should only get $132 million." I think we have made some progress this year in coming to better agreement within VA with the Comptroller's Office and the IG on the definition of equipment needs. The acquisition people, supply people, have been working, had the lead on that and worked with us very closely, and I think we are in a better position to document what the real backlog is and what the needs are.

Mr. **Steinberg**. We would appreciate whatever you could submit on that. And I thank you for that answer.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

A categorized listing of the equipment backlog is presently being compiled. The list identifies equipment necessary to meet VHS&RA critical clinical needs, with the following category identifiers, and with associated costs:

Equipment that must be replaced as it is totally unusable or has unacceptable downtime.

Equipment that must be replaced as it is technologically obsolete and does not meet the current accepted standard of care.

Equipment that must be modified (upgraded) to meet the current accepted standard of care.

Equipment that has been cited, or is anticipated to be cited, as warranting replacement by a JCAHO, OSHA, Fire/Safety or other external reviewer.

Equipment that is needed to contribute significantly to the recruitment or retention of personnel.

That listing is only partially complete, and it is anticipated that it will be available, as requested by the beginning of May 1989.

Mr. **Steinberg**. Anne Pope, the Director of Social Work at the Hines VA Medical Center, this morning testified that women veterans were being disproportionately affected by the shortfall when B and C care was discontinued because, first, they didn't have service-connected disabilities generally, and therefore fit into category A, and they generally had higher income levels, and I believe the Advisory Committee on Women Veterans has raised that issue as well, and we have been thinking about that and concerned that such cutbacks could very well serve to erode, if not reverse, the important gains which your system has made over the last 4 to 5 years in increasing its capacity to treat women veterans. And we were wondering if you share that concern and if there is any special effort under way to try to ensure that that critical capacity is not eroded or destroyed.

Dr. GRONVALL. I surely share that concern, and I think the enhancement of both capacity and sensitivity to women's care issues is one of the success stories in our hospital system and our Women's Advisory Committee has been very complimentary in professional testimony on that issue within the past year. I think we have been between a rock and a hard place on the issue that we, in restraining care, follow the statutory priority system that sorts veterans into category A, B, and C, and I think the negative impact in regard to women is an outgrowth of that.

What we have tried to do is ensure that we had documentation of whatever the impact is. We will look to our Women's Advisory Committee to make recommendations to us, in addition to pointing to the problem, to get more specifically into detail, and it is something that we surely want to be sensitive to. But in the kind of short run crunch set of actions that our medical centers have had to take this year, just in this 5- or 6-month period, I think that has occurred as a result of following a prioritization system that did not take into account gender as a special category in regard to eligibility for care.

Mr. STEINBERG. I think I would differ with you in one respect in describing the prioritization category. Congress specified which groups of veterans you had to treat, and then established two other discretionary categories. It in no way suggested that you could not, within those discretionary categories, establish other priorities, and you are free, certainly, in terms of inpatient care to do so, and in terms of outpatient care, there are, as you know, some further statutory priorities. And you have authority specifically as to those statutory outpatient priorities to add to that list.

So it seems to us that you have the authority to address this problem. We don't know how it should be addressed exactly, but you do have the authority, and I don't understand you to be suggesting that you don't have that authority.

Dr. GRONVALL. Correct. I am not suggesting that. But I think we have not clearly fully addressed that, and it requires some work and thought, and we looked to our staff and the Women's Advisory Committee to give us some help on that.

Mr. STEINBERG. Would you give us some timetable in your addressing it, or at some date in the future by which you might be able to get back to us to tell us how you are addressing it?

Dr. GRONVALL. You have asked for all kinds of followup information which we will be submitting in the next week or two, and I think in that we ought to make a comment about the process of timetable we would use to address that question.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

Women make up 4.4 percent of the veteran population. According to the survey of women veterans done in 1985 for the Veterans' Administration by Louis Harris and Associates, approximately 20 percent of all women who served in the military were officers. The majority of these (75 percent) were nurses although nurses only comprised 16 percent of the total: 26 percent of World War II veterans, 19 percent of Vietnam era and only 3 percent of the post Vietnam era veterans. The largest group of women veterans served in clerical positions but this proportion has been decreasing as the job assignments broadened in the post Vietnam era. The most recent information available from the Department of Defense (1987) shows that 14.5 percent of women currently serving in the military are officers. Fifty-nine percent of all women veterans are married and therefore have access to their spouse's source of income as well as their own. According to the Survey of Women Veterans, the median household income was $21,352. However, 31 percent had household incomes less than $15,000. The Advisory Committee on Women Veterans continues to identify outreach to women veterans as a top priority since many women veterans are unaware of their benefits. For 11 of 18 veterans benefits programs, less than half of the women veterans surveyed said they had heard of them. Outreach efforts to reach women veterans have been hampered by the necessity to restrict access to categories B and C. VA will address the demography of categories A, B, and C by medical district and casemix. VA will continue to strive for equity in the provision of all health care services.

Mr. STEINBERG. The date we would like to shoot for is the 14th for getting back to us, and if you would at that time tell us what your timetable could be on this, we would appreciate it.

Dr. GRONVALL. OK.

Mr. STEINBERG. Dr. Parthemore and others this morning testified about the impact of low salaries and lack of available supplies and equipment on recruitment and retention, and particularly focusing for the moment on physicians.

Do you have plans to try to deal with the difficult recruitment and retention problems which, obviously, a number of your facilities are facing in the physician area?

Dr. GRONVALL. We surely do. We are nearing completion of a report which, by statute, we make now every 4 years, dealing with the issue of physician compensation, so we have a comprehensive report with detailed documentation of salary shortfalls that would document what Dr. Parthemore said here, together with recommendations for taking corrective actions. That report is, as I said, nearing completion, will go to the Secretary, and then to the President, and it will require legislative action to implement the recommendations. But we surely address the matter.

Mr. STEINBERG. Do you have a timetable for when you think that you will see something?

Dr. GRONVALL. I believe it is to be to the President and to the Congress by the end of April, but I need to check that for sure, but we are virtually done with the report.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

The Quandrennial Report to the President on the Adequacy of Special for VA Physicians and Dentists is scheduled to be forwarded to the Office of Management and Budget by June 30, 1989.

Mr. STEINBERG. Earlier there was a reference to the 25 percent pay increase that is being considered, according to newspaper reports, within the administration, as to certain scarce categories of

Federal employees, particularly those with particular technical skills.

Has the Department made any input within the executive branch to consideration of that kind of a pay proposal as to your physicians or as to categories of your physicians?

Dr. GRONVALL. If we have, I am unaware of it. It may well be that the personnel office of the Department of Veterans Affairs has been asked and has provided input, but as I say, I am unaware of it. The physician salary issue, we have been dealing with as a specific title 38 issue, where we have a statutorily established process for making quadrennial reports and recommendations on pay. So those are two separate but interrelated topics. And I have no personal knowledge of the process being used by the administration now to resurrect some kind of a pay proposal for senior executives in the Federal Government.

Mr. STEINBERG. Would you bring this to the attention of those who may be concerned with that process in the agency?

It seems to us that if something may be forthcoming, that, for example, as some reports suggest, would increase pay for senior NIH investigators, that it would be unfortunate for the VA to lose the opportunity to gain a benefit from such increases.

Dr. GRONVALL. I absolutely agree. I will call attention to that question.

Mr. STEINBERG. Report back to us as to the answer?

Dr. GRONVALL. Report back to you, yes.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

The Department of Veterans Affairs has not been contacted relative to the administration's plans to increase pay for senior NIH investigators and other categories of Federal employees.

Mr. STEINBERG. Thank you.

A final, I am sure you will be glad to hear, question relates to some reports that we have been receiving that the funding shortfall is raising some major problems regarding PTSD activities.

First, we understand that at many medical centers, various budget-imposed restrictions are resulting in veterans who come to you for PTSD diagnosis and treatment being turned away before receiving any diagnosis.

It was our understanding that the policy that has been implemented to this point, even in those facilities which are restricting category B and C care, is that all veterans, regardless of category, are to be evaluated.

Is our understanding of that policy correct?

Dr. GRONVALL. Correct. Our policy is that any veteran who applies for care must have a professional evaluation of what the problem is and what kind of care is necessary, and then the eligibility criteria get laid on on top of that, and a decision then made whether we have the mandate or capability or capacity to provide the care.

Mr. STEINBERG. And does that evaluation extend to applicants who are presenting with mental illness symptoms?

Dr. GRONVALL. Yes.

Mr. STEINBERG. Is there any ambiguity about that?

Dr. GRONVALL. No.

Mr. STEINBERG. So that, if an individual who was in category B presented with such symptoms, he would see a mental health professional for diagnosis, or evaluation?

Dr. GRONVALL. There would be—let me answer that this way. In every case, a veteran coming for any kind of problem will have a competent and appropriate professional evaluation.

Mr. STEINBERG. Well, can any evaluation be provided to an individual presenting, for example, with PTSD symptomatology by other than a mental health professional?

Dr. GRONVALL. Well, I didn't want to tie it down that closely to say that, just because an individual may have symptoms which relate to behavior or mental issues, that the only person who can make some kind of competent evaluation is a mental health professional, narrowly defined.

Mr. STEINBERG. An individual comes in and says, "I think I have a mental problem, a mental health problem that has to be dealt with," doesn't that ipso facto, if you are going to evaluate that individual, require that, at a minimum, the individual be evaluated by somebody with particular skill in evaluating and diagnosing mental illness?

Dr. GRONVALL. I wouldn't be willing to say that a physician, internist, let us say, is unable to competently assess an individual who presents and, among the complaints the individual has are "behavioral or mental health" symptoms.

Mr. STEINBERG. I didn't posit a case of an individual presenting with a variety of symptoms among which were such symptoms of mental illness, but the case of individuals presenting with only those symptoms. And we believe that what is happening across the system now is that those individuals are not being evaluated or diagnosed, and therefore, are not being appropriately dealt with, and are certainly not receiving treatment, and, obviously, even the possibility of their receiving an adjudication of service connection in connection with a possible PTSD situation, is dramatically reduced if they don't get through the door in terms of the threshold.

Now, we have had this discussion with a somewhat different emphasis from this at a number of prior hearings and, indeed, you have had it with Senator Cranston as well, as has the Secretary. We are all aware of the data in the RTI report. You have not disputed that data. Your department has not disputed that data. Indeed, you said that, as far as you know, it is a very reliable and appropriately conducted report and survey.

According to that report, close to half a million Vietnam veterans are today suffering from PTSD, with an additional some 350,000 or so suffering from various PTSD symptoms, and RTI has other data, as well as, we understand, the estimates of your own special committee on PTSD, are that the vast majority of those individuals have never received any treatment of any kind from you or anyone else for that condition.

And we are getting reports now that individuals who are coming to you with that condition that appears to exist in great quantity in the Vietnam veteran population, are, in essence, being turned away and turned off, which is a very dangerous thing to do with somebody who may have mental illness. And it seems to us that this problem needs to be addressed in a particular fashion, given the results of that report. I know you have a task force that is working on evaluating that report, but if right now we have veterans who are coming to the system to try to get care, and that is what the system exists for, to try to take care of veterans who have conditions that are related to their service and they are not getting that care, then it seems to us we have a problem now that shouldn't have to wait for a task force process to work itself through the Department.

Dr. **Gronvall**. I think the best way for us to respond would be to respond in writing, with comments about the extent to which we believe there exists a problem as a result of lack of appropriate professional evaluation of such individuals who are applying to us for care, and I would be pleased to do that.

Mr. **Steinberg**. Would you also consult with the experience of your vet centers in terms of what is happening to referrals that they make to your medical centers and how that differs today from the way it was in the past?

Dr. **Gronvall**. Yes. I surely will.

Mr. **Steinberg**. Would you consider, in responding to us, this proposal that might help ameliorate the problem that we are receiving reports about, and that is that it be required that evaluation and diagnosis be provided for any veteran who is referred to a medical center by a vet center for mental health care, or for any veteran who presents for PTSD care at one of your medical centers that has either an inpatient PTSD unit or a PTSD treatment team, so that, in either of those instances, that individual must receive evaluation and diagnosis, and then, if your diagnostician finds medically that that individual is indeed afflicted with PTSD, then requiring that the individual be provided care in such instances?

Dr. **Gronvall**. We will surely consider any such specific proposal. The last part of that sounded like a new kind of category A mandate, namely, that, on a diagnostic basis, any individual veteran for whom a given diagnosis is made, shall be provided care by the Veterans' Administration.

Mr. **Steinberg**. It sounds very much like legislation which was passed by the Senate last year and has been reintroduced this year, and in opposition to which you testified.

Dr. **Gronvall**. We always obey laws which have been adopted by the Congress and signed by the President, and I think when you make that kind of suggestion to me at a hearing, and it surely does sound like a legislative prescription, my answer is yes, we would certainly be glad to consider that and comment on it.

Mr. **Steinberg**. As we said before, you have the authority to implement that priority yourself, if you wish to, or not. But the earlier point that we made about the evaluation and diagnosis remains a concern and what we were suggesting is that one way of controlling this and keeping it, perhaps, in manageable proportions, would be, first of all, to use the screening mechanism which exists in your own vet centers who make a referral, and second of all, to use the expertise that you have at your own inpatient PTSD and at your medical centers, some 25 of whom—I am sure I don't have the right number—which have special PTSD treatment teams.

So I leave that suggestion.

Dr. **Gronvall**. Thank you. And I think the best thing is for us to review that and make whatever comment on it we think is appropriate.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

A growing impression with the Readjustment Counseling Service is that it is becoming increasingly difficult for category B and C veterans to receive evaluation and treatment for PTSD at VA ~~medical~~ centers (VAMCs). In fact, increasingly numbers of category B and C Veterans are being referred to vet centers by VAMCs. However, in order to respond to this question fully, a survey of vet centers will be conducted to determine if veterans referred from vet centers to VAMCs have been denied clinical assessments. We will also survey VAMCs to request information concerning denial of requests for clinical evaluations particularly for veterans presenting with symptoms of PTSD.

Veterans who seek or are referred to VAMCs for clinical evaluations may begin the assessment process with a specialist in the clinical area appropriate to the veteran's symptoms. However, as the assessment progresses, if symptoms of mental illness are also uncovered, the veteran is referred to a mental health professional for further evaluation. Conversely, veterans who present with symptoms of mental illness are referred to VA mental health professionals for initial assessment and if symptoms of other disorders are uncovered, the veteran is referred to another clinical specialist for further evaluation.

In some instances PTSD may not be easily recognizable as a source of difficulty. Veterans may not realize that they are suffering from PTSD and may not initially report symptoms of PTSD as a reason for seeking assistance. In fact, many veterans with PTSD initially appear to have substance abuse disorders because they tend to use alcohol and other drugs as self medications in order to deal with the symptoms of PTSD. Several years ago the Veterans Health Services and Research Administration (VHS&RA) issued policy to require that veterans be questioned about their military and combat histories during early screening procedures. This policy was designed to help clinicians identify potential PTSD problems during the initial assessment phase. We believe that this policy has been implemented successfully at most VAMCs and has led to earlier recognition of PTSD symptoms and referrals to appropriate VA mental health professionals for further assessment and treatment.

Mr. **Steinberg**. Finally on PTSD, we are concerned about the future of the Chief Medical Director's Special Committee on PTSD. As you know, the Senate last year passed legislation to mandate its continuation for 3 more years, and S. 13, which Senator Cranston introduced on the 25th of January, is pending in this committee—I am quite sure it will be favorably reported—and it includes a provision identical to that passed by the Senate last year. We have talked about the RTI report findings. In view of those and the pendency of this extension legislation, and we believe that similar extension legislation is contemplated on the House side, do you have any plans to discontinue or reduce funding for the special committee this fiscal year or next?

Dr. **Gronvall**. No.

Mr. **Steinberg**. Do you have any plans to alter the committee's lines of reporting, apparently reports to you as a result of the congressional directive in the legislation?

Dr. **Gronvall**. No.

Mr. **Steinberg**. Do you have any plans to preclude it from submitting its reports directly to the Congress?

Dr. **Gronvall**. No.

Mr. **Steinberg**. Do you know whether there is any plan affirmatively that it would continue to function as it has functioned until Congress makes a disposition one way or the other in the course of this fiscal year? Is that your policy?

Dr. **Gronvall**. I believe the answer to that is yes.

Mr. **Steinberg**. If either that policy changes or there are any changes in your intentions with respect to the previous three questions that I asked about the special committee, would you agree to give the committee at least 90 days advance notice of the implementation of any such policy changes?

Dr. **Gronvall**. Yes.

Mr. **Steinberg**. Thank you very much.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

The Chief Medical Director's Special Committee on Post-traumatic Stress Disorder (PTSD) was established by section 110(b) of Public Law 98-528. As required by the law, members of the Special Committee are to be qualified VA employees. Responsibilities of the Special Committee include carrying out a continuing assessment of the VA's capacity to provide diagnostic and treatment services for veterans with PTSD and advising the Chief Medical Director on the development of policy and guidance and the coordination of service for the diagnosis and treatment of Committee. The Special Committee is also responsible for making recommendations to the Chief Medical Director concerning the diagnosis and treatment of PTSD, the conduct of PTSD research, PTSD educational activities and the allocation of resources for all PTSD activities. A separate paragraph of this section of the law (section 110(e)) required the Administrator to submit five annual reports to Congress on the implementation of provisions contained in section 110 of Public Law 98-528. Among other things the reports were required to contain the recommendations made by the Special Committee to the Chief Medical Director and the views of the Chief Medical Director on such recommendations. The VA's 1989 report is the fifth and final report to Congress required by this legislation.

Over the past 5 years, the Special Committee on PTSD has provided sound advice and recommendations to the Chief Medical Director concerning the diagnosis and treatment of PTSD and educational and research activities relating to PTSD. The Veterans Health Services and Research Administration (VHS&RA) has supported and continues to support the Special Committee through the dedication of travel funds ($30,000 per year), and funding for salaries to provide support for Dr. Matthew Friedman, Chairman of the Special Committee. In addition, funds were provided to the Great Lakes Health Services Research and Development (HSR&D) Field Office to conduct a survey on PTSD treatment in outpatient programs.

Recent legislation has been introduced that would continue the CMD's Special Committee on PTSD for 3 years and would require the Special Committee to submit annual reports simultaneously to the VA and to Congress. The VA would be required to submit a report discussing the Special Committee's report 30 days after receipt of the Special Committee's report. This proposed legislation alters significantly the role of the Special Committee. The Special Committees will no longer serve as an advisory group to the Chief Medical Director, but rather will serve as an advisory group to the House and Senate Veterans' Affairs Committees on matters relating to PTSD. We are unaware of any past or current VA advisory groups composed exclusively of VHS&RA staff that have been required to report directly to Congress and we believe there are distinct disadvantages in setting this precedent. The congressional committee will be perceived as managing and directing activities that are the responsibility of the Chief Medical Director. With the Special Committee reporting directly to Congress there may be significant constraints upon open and honest exchanges of information between members of the Special Committee and other VA staff. In many ways, the value of the Special Committee as a source of information for VHS&RA will be lost. Finally, the congressional committees will not be provided a balanced perspective with respect to PTSD issues. In general, we believe that having the Special Committee report directly to Congress will compromise the excellent working relationships that have been developed between the Special Committee, staff in VA Central Office and congressional staff and will minimize the impact that the Special Committee can have on PTSD activities.

Mr. **Steinberg**. Dr. Gronvall, as always you have been remarkably informative, well informed, and responsive in a very candid and forthright way to our questions. We greatly appreciate that, and we greatly appreciate your and the Secretary's generosity in making your time and expertise available to us for this hearing. It has been very worthwhile from our standpoint. And we thank you very much for being with us.

Dr. **Gronvall**. Thank you.

Mr. **Steinberg**. Let me ask Lisa Moore, who is representing the minority staff director, Al Ptak, if she has any questions that she wants to pose.

Ms. **Moore**. No.

Mr. **Steinberg**. Thank you, Lisa.

Finally, I want to note that we will print in the record at the appropriate place earlier, the April 3 letter from Senator Cranston and the April 5 response from Secretary Derwinski, so that will be available when this hearing is published.

We have made that report, that letter, available at the press table so that members of the audience will have access to it. We thank you all for your attendance, and this hearing is adjourned.

[Whereupon, at 1:10 p.m., the committee was adjourned, to reconvene at the call of the Chair.]

APPENDIX

Opening Statement
Senator Alan Cranston
Chairman, Committee on Veterans' Affairs

Oversight Hearing on Department of Veterans Affairs Health-Care Funding
April 6, 1989

Good morning and welcome to today's oversight hearing of the Committee on Veterans' Affairs. Today's hearing is a follow-up to the two days of hearings our Committee held last September on the state of funding for VA's health-care system and our March 6 hearing on veterans' programs budgets. At the September hearing, which was just prior to the start of the current fiscal year, we heard very compelling testimony about the severity of the problems facing the system and predictions about how the budget woes would affect the quality and quantity of VA care in FY 1989.

Today's hearing -- at a time just past the half-way mark of the fiscal year -- should give the Committee the opportunity to update that earlier information, both so as to continue our ongoing oversight of VA's health-care system as well as to gain current information as we go forward in the all-important budget and appropriations processes. I am convinced that we need both major supplemental funding for the current fiscal year as well as significantly increased funding levels -- in both cases well beyond funding requested by the Administration for FYs 1989 and 1990.

The lack of adequate funding is the most pressing problem in the VA system today. As Chairman of this Committee, I have made efforts to restore adequate funding for VA health care a top priority, and I am delighted to note that the Senate Democratic Conference in the Legislative Agenda it adopted very recently did so as well.

As we approached the end of the 100th Congress, tremendous VA health-care funding difficulties became painfully obvious. When it appeared that many VA medical centers were headed toward fiscal disaster in the waning months of FY 1988, I was able -- despite the Administration's refusal to heed VA's desperate call for help -- to propose and obtain enactment of a $31.7-million FY 1988 supplemental appropriation for VA medical care.

At our September 1988 hearings, VA medical center directors, doctors, and nurses virtually unanimously described, under oath, the then-existing fiscal state of affairs as a "crisis" and "the worst financial crunch" they had ever seen in VA health care. We intend through the testimony of the field witnesses who are appearing today to see how, if at all, things have changed since then and about the impact on individual veterans seeking VA care.

According to VA's Chief Medical Director, Dr. John Gronvall, at the September 9 hearing, the FY 1989 deficit was projected to be $635 million. That, I believe, was a very conservative estimate. Other credible estimates received then placed the shortfall at as much as $1.1 billion, taking into account the need to address the enormous and growing -- by then over half-billion-dollar -- backlog of equipment purchases and repairs and building maintenance items.

Also, in connection with that hearing, then-Administrator Thomas K. Turnage, who had consistently failed to acknowledge the crisis as it worsened, conceded a need for additional FY 1989 medical care funding of $432 million and finally requested the Office of Management and Budget's approval for FY 1989 supplemental funding.

On October 11, 1988, I initiated a letter to President Reagan signed by 24 other Senators urging the prompt submission of an Administration request for supplemental funding before the 100th Congress adjourned. Unfortunately, no such request was forthcoming from the Reagan Administration.

Because adequate funds were not made available for FY 1989, Dr. Gronvall decided VA could no longer risk compromising the quality of care furnished and, instead, chose to give individual facilities the option to reduce services, close specific programs, and decrease the workload. Early this year, to learn more about the impact of this approach, I wrote to directors of over 50 VA medical centers -- four of today's VA field witnesses are from medical centers in that group -- asking them to provide the Committee with copies of all issuances describing proposed or implemented reductions in services or changes in programs as a result of the budget shortfall and to provide quarterly updates. I have forwarded materials received to the Senators from those States.

The 41 replies we've gotten thus far show a continued erosion in VA health care. These reports indicate that thousands of veterans are being told, after years of receiving VA care, to go elsewhere or that they must wait long periods of time -- in many cases a denial of care in and of itself -- before receiving certain types of care or prostheses. Numerous programs and services are being cut back or eliminated altogether, including hospital-based home-care services, alcohol and drug treatment centers, and VA and community nursing home care, to name just a few. Over one-third of the facilities that have thus far replied have cut off inpatient or outpatient care or both for veterans who are not in Category A.

There is a growing concern across the system that, despite the best of intentions, the quality of VA care is suffering as a consequence of the budget shortfall. That simply cannot be allowed to happen without every effort being made to correct the situation.

I am also deeply concerned about VA's ability to attract and retain sufficient health-care personnel needed to staff the system. Not only does VA face significant difficulties in being competitive with non-VA health-care employers in terms of salary and benefits, but the Department is also further handicapped in its recruitment and retention efforts because of the understandable concerns of many would-be recruits about the future of the system in light of the funding crisis. I will shortly be introducing major recruitment and retention legislation with special focus on VA registered nurses.

Unfortunately, the Administration has responded to this problem with too little, too late. First, President Reagan's budget for FY 1990 contained no request at all for supplemental medical care funding for FY 1989, and his medical care budget for FY 1990 included a request for a $200-million increase -- far less than the amount required to counter inflation -- over what has turned out to be a totally unacceptably low level of funding for the current fiscal year.

On February 7, then Secretary of Veterans Affairs-designate Edward J. Derwinski wrote me to report that he had submitted to OMB requests for an FY 1989 medical care supplemental of $314 million and for $512 million in additional medical care funds for FY 1990. Nevertheless, the budget changes that President Bush presented to Congress on February 9, 1989, failed to address the current or continuing FY 1990 VA funding crisis. Worse still, the Bush budget called for a flexible freeze on the total expenditures for a $136-billion block of domestic programs including VA health care; if such a freeze were applied to the VA medical care account, it would mean a reduction of $200 million below even the unacceptably low Reagan FY 1990 medical care request.

Because of our grave concern about the continuing reductions in health-care services, 40 Senators joined me in a letter to President Bush urging him to submit FY 1989 and FY 1990 requests for additional VA medical care funding. I also wrote to and met with the two new heads of the appropriate House and Senate Appropriations Subcommittees to bring them up to date on VA needs and to urge them to support supplemental FY 1989 funding. We had very encouraging and constructive discussions. And along with other Senators and House members, I met with OMB Director Richard Darman on March 1.

Our March 6, 1989, hearing on the FY 1990 budget for veterans' programs highlighted many of the acute problems in the VA health-care system today: Inadequate funding for staffing, for research, for equipment, and for supplies, as well as cuts in the services provided to veterans.

On March 8, our Committee met to adopt recommendations to the Senate Budget Committee on the budget for veterans' programs. I proposed -- and by a bipartisan vote of 8-3 the Committee agreed -- that we recommend $618.4 million in supplemental FY 1989 VA medical care funding and an additional $1.24 billion for FY 1990 over the Administration's request for VA medical care. These increases are needed to restore patient workloads and health-care staffing to approximately FY 1988 levels and to begin making the efforts necessary to deal with the growing needs of veterans for long-term care, the enormous unmet needs of Vietnam combat veterans for post-traumatic stress disorder treatment, the escalating demands for and costs of AIDS treatment, the great numbers of homeless veterans, and the need to fight the epidemic of drug and alcohol abuse.

On March 24, the Bush Administration finally submitted a supplemental request for FY 1989 VA medical care. The amount requested -- $303 million -- is too little, too late. Sadly, half the fiscal year has already passed, and no increase was proposed for FY 1990.

I will continue my work for higher funding levels. At this point, I am confident that Congress will enact FY 1989 supplemental appropriations for VA medical care and will increase substantially the Administration's FY 1990 medical care request.

I expect today's hearing to help in those efforts, and I want to thank all of the witnesses who are appearing today for their willingness to come forward and to share with us their personal and professional views on what is going on in VA's health-care system.

I have two announcements about recent VA actions relating to the shortfall -- both of which I view as positive. First, at our Committee's March 6 budget hearing, I expressed concern to the VA's Deputy Chief Medical Director, Dr. Art Lewis, that some VA medical centers were discontinuing the provision of over-the-counter drugs and other non-prescription items to service-connected veterans. I indicated my strong view that this was not an appropriate policy and asked Dr. Lewis to look into it. I am pleased to note that the VA, on March 13, directed all field facilities to continue providing these items, as needed, to all veterans being furnished VA care.

Second, at that same hearing, I asked Secretary Derwinski to review decisions of individual medical centers to close substance abuse programs as cost-saving measures. On March 20, Secretary Derwinski responded that, effective March 3, he had "advised the Chief Medical Director that all VAMC policy changes with the potential of impact on access to non-emergent care should not be implemented" until the Secretary receives official notification of the intention to carry out such changes and then approves the change. Secretary Derwinski also noted that, until further notice, "decisions regarding the closure or reduction of substance abuse programs will no longer be at the discretion of the individual medical centers."

I want to note that we will place all witnesses at today's hearing under oath before they testify, and I want to explain why.

First, I believe that VA staff members who have appeared before our Committee are a talented, highly professional, and honorable group of individuals. I thus want it to be very clear that the administration of the oath is in no way intended to impugn any witness's integrity.

The background of this matter pertains to representations at our Committee's March 8, 1988, hearing that the Administration's budget for FY 1989 contained ample resources for VA to care for all eligible veterans who were expected to apply for and be in need of health care. Within a matter of months, however, it became clear that, even with the additional $215 million that Congress appropriated to the medical care account, VA was facing a dire financial crisis in its health-care facilities in FY 1989.

In light of those developments and also to provide a form of protection to VA witnesses from Central Office and field stations in order to get candid, first-hand impressions of the situation, I decided to require all witnesses at our Committee's September 9, 1988, oversight hearing on the budget problems of VA health-care facilities to testify under oath. In stark contrast to the overly-optimistic picture presented at the earlier hearing, that September hearing produced a shocking portrayal of a health-care system that was experiencing its worst financial crisis and was clearly unable to provide needed care to many thousands of the veterans who would be seeking it in FY 1989. I have since received several comments to the effect that the use of the oath contributed significantly to the candor and openness that was so evident on that occasion.

Consequently, I decided that, for the foreseeable future, all Committee budget hearings as well as oversight hearings with VA field personnel should follow that same format, and we will do so today as we did at our March 6 budget hearing.

STATEMENT OF DENNIS DeCONCINI
OVERSIGHT HEARING ON VETERANS' HEALTH CARE
SENATE COMMITTEE ON VETERANS' AFFAIRS
APRIL 6, 1989

MR. CHAIRMAN, THANK YOU AGAIN FOR YOUR UNYIELDING LEADERSHIP AND COMMITMENT TO OUR BELOVED VETERANS, MOST PARTICULARLY YOUR ATTENTION TO THE VA HEALTH CARE CRISIS WE HAVE TODAY. LET ME ASSURE YOU THAT I WILL CONTINUE TO SUPPORT YOU IN EVERY WAY THAT I CAN.

I AM TRULY SORRY THAT I CANNOT ATTEND THIS HEARING DUE TO AN UNAVOIDABLE SCHEDULING CONFLICT WITH ANOTHER HEARING BEFORE THE APPROPRIATIONS SUBCOMMITTEE ON DEFENSE. HOWEVER, I LOOK FORWARD WITH GREAT INTEREST TO REVIEWING TODAY'S TESTIMONY.

MR. CHAIRMAN, I WOULD LIKE TO INTRODUCE TO YOU TODAY ANOTHER DEVOTED ADVOCATE WHO HAS SPENT MOST OF HIS CIVILIAN LIFE CARING FOR THE NEEDS OF VETERANS, MR. LARRY DAWSON. HIS FRIENDSHIP AND GREAT KNOWLEDGE HAS BEEN INVALUABLE TO ME. I COMMEND HIM HIGHLY TO YOU AND MY COLLEAGUES ON THIS COMMITTEE. I SHOULD ADD THAT THIS IS NOT THE FIRST TIME THAT LARRY HAS TESTIFIED BEFORE THIS COMMITTEE. IN 1982, MR. DAWSON WAS INSTRUMENTAL IN THE COORDINATION OF THE FIRST VETERANS HEALTH CARE FIELD HEARING IN ARIZONA. I TRUST HIS PARTICIPATION IN TODAY'S HEARING WILL BE AS BENEFICIAL TO OUR EFFORTS TODAY AS HIS MANY YEARS OF SERVICE TO ME AND THE ARIZONA DEPARTMENT OF THE DISABLED AMERICAN VETERANS HAS BEEN TO ADDRESS THE NEEDS OF THE ARIZONA VETERAN COMMUNITY.

Statement by
Senator James M. Jeffords

Senate Veterans Affairs Committee
Oversight Hearing on Health Care

April 6, 1989

Mr. Chairman, I am very pleased that you were able to reschedule this hearing so soon. As the newest member of the committee, I am very anxious to hear firsthand from some of the individuals who are grappling every day with the problem of trying to provide quality health care with limited resources.

This is a very difficult time for veterans in need of health care. The comprehensive medical care that we have provided to nearly all veterans for several decades has been curtailed. The dwindling resources available to the Department of Medicine and Surgery have led to the implementation of priorities for certain categories of veterans.

In many cases these reductions have been implemented very quickly, without much warning to the veterans who have been affected. We simply must do a better job of anticipating what services the veterans health care system will be able to provide and of letting people know about any likely changes. To the extent that some categories of veterans will not be eligible for treatment at a Department of Veterans Affairs facility, they need a reasonable amount of time to plan for medical care at an alternative facility.

The failure to provide adequate warning to veterans has created a great deal of uncertainty and mistrust. A number of veterans have asked me if there will even be a VA health care system in the next five, ten or fifteen years. This mistrust greatly concerns me.

It will not be easy to ease peoples' minds about the future of the veterans medical system and to change the negative perception that some people have developed. However, I think that it is important that we be "up front" with veterans. We should remain firm in our commitment to high priority veterans, but we must be careful not to raise peoples' expectations unrealistically.

I am grateful for the opportunity that this hearing provides to look into these important issues.

I would like to take this opportunity to welcome a member of this panel, Gary Degasta. Gary is the director of the veterans medical center in White River Junction, Vermont. He is appearing before the committee today to testify about his first hand experience in tackling some of the big problems faced by small veterans hospitals around the country. I have a lot of respect for Gary and his staff at the White River Junction facility. I know from my visits to the hospital that they are doing their best to provide veterans with quality health care in spite of the limited resources available to them.

SENATOR BOB GRAHAM
STATUS OF VETERANS ADMINISTRATION HEALTH CARE FUNDING
APRIL 6, 1989

Mr. Chairman, thank you for calling this hearing today to address what is one of the most serious issues facing the Veterans community, access to quality health care.

We are faced with what has been conservatively estimated to be a $635 million shortfall in the Department of Veterans Affairs medical care account for fiscal year 1989. The VA has come to a critical point in its existence.

The shortfall has called into question the ability of the VA to adequately and competently deliver health care to our veteran population. We are sacrificing the future to meet the needs of the present. This is intolerable.

Mr. Chairman, I am well aware of the problems caused for veterans in my State due to insufficient funding. As you know, I held a field hearing in Orlando on March 23 to explore this issue and was very concerned with what I heard.

Florida has emerged as the only large state with rapid growth in its veteran population. Florida has both the highest incidence of service conntected disabled veterans and the most seriously disabled veteran population in the country.

Yet it also has experienced some of the most pronounced reductions and shortages in resources and manpower. As a result, Florida has the largest number of claims denied.

One after another men and women who served our country testified at our Orlando hearing about long delays in receiving care and often outright denial of services due to the lack of resouces in local VA medical centers and outpatient clinics.

One veteran testified that he waited eight months to get an eye exam. Another waited 3 months to get a cardio vascular examination. A private sector hospital social worker explained the virtual impossibility of transferring patients to VA medical centers, especially for those who have never accessed the VA system or have a non-service connected disability.

These veterans were appreciative of medical staff efforts to assist them, but their patience was wearing thin.
In fact, the Medical Director of District 12, which includes Florida, voiced the concerns of VA medical staff regarding the effects of the budget shortfall on their professional and ethical responsibilities.

Malcom Randall said, "Continuing this practice of rationed health care may lead to the physican staff leaving VA employment if they are forced to withdraw tretment from chronically ill patients in this fashion."

Mr. Chairman, too many veterans are being turned away from VA hospitals because they are in the "wrong" category. VA hospitals are experiencing shortages in manpower, particularly nurses, pharmacists, and other health care professionals.

There is a tremendous backlog in equipment purchases because VAMC's have been forced to divert money from equipment purchases to pay for personnel costs. These are examples of how the budget shortfall has impacted on the VA's medical system.

While the Veterans Administration has recommended a supplmemental appropriation for FY89, more is needed to meet our obligations for the current fiscal year. I am certainly sensitive to limitation on the government's financial resources, but I believe that our veterans deserve priority status as Congress begins its budget process.

These hearings on the health care needs of our nation's veterans will help us establish the record necessary to make important appropriation and health care policy decisions.

Thank you, Mr. Chairman.

STATEMENT OF SENATOR FRANK H. MURKOWSKI (R-AK)
COMMITTEE ON VETERANS' AFFAIRS HEARING, APRIL 6, 1989

Good morning and welcome to the Committee's hearing on the Department of Veterans Affairs medical-care funding situation. I am not totally clear on the purpose of this hearing. We know that the funding levels affect the delivery and availability of care to veterans. There is nothing new about that. The availability of care has always been subject to the availability of resources. It has always carried with it the implication that care might not be available to every veteran for every illness. I believe, therefore, it might be a more productive use of Committee time to examine the effectiveness of VA's fiscal policy -- not receive anecdotal information on the VA's "denial" of care to veterans.

As many of you know, President Bush sent to the Congress a fiscal year 1989 supplemental funding request for VA medical care of $303 million. I understand that Secretary Derwinski personally met with the President to discuss the need for supplemental appropriations for veterans' health care. I congratulate the Secretary for his untiring efforts to obtain these additional funds. The House Subcomittee on VA, HUD and Independent Agencies approved the supplemental several days ago.

Although I do support the supplemental request that was sent to the President, I remain extremely concerned about the financial condition of the United States. Our Country faces a dire crisis -- the Federal budget deficit. We have Gramm-Rudman-Hollings budget reduction targets to meet. We established these targets because the Congress recognized that the burden of the deficit threatens all programs, including veterans health care as well as the economy that supports them. And we have many serious problems which we now face, such as:

- the Savings and Loan Crisis, Savings and Loans in which veterans deposit money,
- the clean-up of nuclear weapons production facilities, facilities located in communities where veterans live, and
- rebuilding our aging bridges and highways, bridges and highways used by veterans.

The needs of the Country are great, but the money necessary to accomplish our goals is limited. We cannot do all things for all people. And this includes our Nation's veterans.

In this regard, it is the responsibility of the Congress and the Executive Branch to make budgetary decisions. We must re-examine the effectiveness, mission, and need for every government program, including every VA program and facility.

I recognize that some of my statements may be controversial, but this Committee and the new Department desperately need to examine all VA programs. No program or facility should be considered "off limits". We should explore VA programs either directly or by special independent commissions. I want to mention just a few examples of issues which need to be carefully examined.

1. Given the large number of aging veterans in the VA system, we need to examine the impact of the Medicare Catastrophic Protection Act on the VA health-care system.

2. Given demographic changes and the changing needs of veterans, every VA facility should be examined to determine if consolidation, mission changes, or closure of VA facilities are needed. I believe that they are. The difficulty is finding an objective and independent method of examination and one in which political considerations are not the issue and would not be able to influence the process.

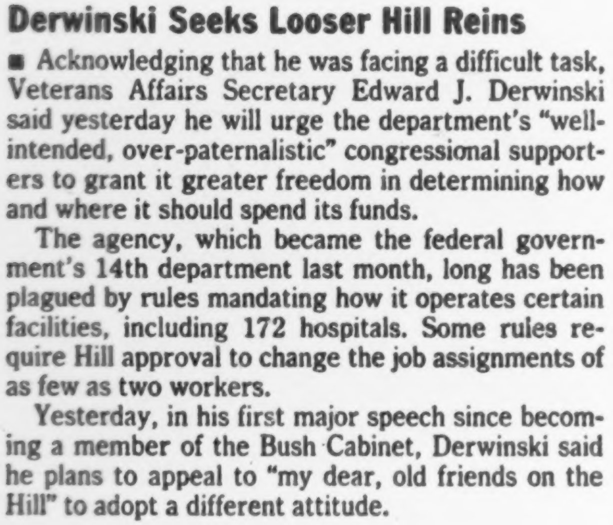
-- For example, two VA facilities in Chicago -- located only 5 miles from one another -- have cardiac surgery programs. Why are both of these programs needed? Obviously they are expensive to staff and operate.

The Congress must give the new Department of Veterans Affairs the flexibility to manage its scarce resources. That means no requirements to maintain a certain staff and bed level. The Department needs such flexibility to respond to the changes in health-care delivery.

I look forward to learning the views of the witnesses, and I hope they will focus their testimony on ways to improve the quality and timeliness of services given current fiscal constraints. We simply no longer have the luxury of saying that "more money" is the only answer. It is certainly the easiest answer, but frankly we can't afford to take the easy way out. Funding will not likely be available to us, no matter how much we might desire it.

Thank you, Mr. Chairman.

(From the Washington Post, April 6, 1989)



Derwinski Seeks Looser Hill Reins

■ Acknowledging that he was facing a difficult task, Veterans Affairs Secretary Edward J. Derwinski said yesterday he will urge the department's "well-intended, over-paternalistic" congressional supporters to grant it greater freedom in determining how and where it should spend its funds.

The agency, which became the federal government's 14th department last month, long has been plagued by rules mandating how it operates certain facilities, including 172 hospitals. Some rules require Hill approval to change the job assignments of as few as two workers.

Yesterday, in his first major speech since becoming a member of the Bush Cabinet, Derwinski said he plans to appeal to "my dear, old friends on the Hill" to adopt a different attitude.

STATEMENT BY SENATOR STROM THURMOND (R-S.C.) BEFORE THE COMMITTEE ON VETERANS' AFFAIRS REFERENCE HEALTH CARE OVERSIGHT HEARING, THURSDAY, APRIL 6, 1989, 8:00 AM, SR-418.

Mr. Chairman:

It is a pleasure to be here today to receive testimony involving oversight of the health care programs in the Department of Veterans Affairs. The quality of health care provided to the veterans of this Country has been a matter of considerable discussion over the past several months.

As the Committee charged with oversight of the delivery of health care to our veterans, we must ensure that the men and women who served this Country are provided with the levels of care they need and deserve. At the same time, we must recognize the reality of competing demands for limited Federal resources. As we approach the decade of the nineties, these competing demands will likely become even more acute.

Accordingly, we must examine with careful scrutiny the entire health care delivery system of the Department of Veterans Affairs, and we must be prepared to make some hard decisions.

For many years now, the Department of Veterans Affairs has been ably providing for the needs of the veterans of this Country. We must continue to see that the health care challenges facing the Department are met in a reasonable and appropriate fashion. The oversight hearing today will certainly provide us with valuable insight into this matter.

Mr. Chairman, I look forward to reviewing the testimony. At this time, I must leave to attend another meeting.

STATEMENT OF
JERRY D. COX
SUPERVISOR, NATIONAL SERVICE OFFICER
DISABLED AMERICAN VETERANS
PHILADELPHIA, PA
BEFORE THE
COMMITTEE ON VETERANS AFFAIRS
UNITED STATES SENATE
APRIL 6, 1989

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE

On behalf of the 58,590 members of the Disabled American Veterans (DAV) and its Ladies Auxiliary of the State of Pennsylvania, I wish to express to you and this distinguished Committee our appreciation for allowing me to speak before you today.

Mr. Chairman, during the past few weeks, I have had the opportunity to talk with VA medical personnel in person and thru intermediaries. I have also talked with the DAV Hospital Service Coordinators who are assigned to various VA Medical Centers and to veterans themselves. The questions put to these individuals were simple, was the budget given to the VA Medical Center sufficient to run the operations and was it felt that the quality of service would decline if corrective action is not initiated immediately?

What came out of these discussions was a feeling of hopelessness among VA employees and fear from the veteran population.

Each of the VA Medical Centers in Pennsylvania will suffer with a budget short fall for Fiscal Year 1989. The range runs from $200,000 to $1.8 million. In order to adjust to this crisis, steps were taken by the Medical Centers to reduce services in order to work within the available funding.

One such area which has been hit hard is staffing. One Medical Center is funded for 1,099 full-time equivalent personnel, which is a reduction of 28 positions from last fiscal year. At the moment, they have a ceiling of 1,133 which equates to 34 above the target. In order to come down to target level, the Medical Center has implemented an employment freeze. This of course will have a long run effect on Medical Center operations. An example of this is the Engineering Service, which has over 10 positions being frozen, which means equipment is not being checked as often and maintenance of buildings and grounds is at a reduced level. Of course this will result in equipment breakdown more often and ultimately will cost the system more.

In checking with other Medical Centers, all agree that Engineering Services, Janitorial and other housekeeping services will be strongly affected by lack of staffing.

When these type of services are cut, the following occurs: On 2/2/89, one of our veterans reported to one of the VA Medical Centers for a scheduled examination on his service connected disability (30%). Upon arriving at the facility, he checked in with the VA personnel in the waiting room and then proceeded to the one and only public restroom in the waiting room area. What the veteran found was appalling. The bathroom was filthy. Blood was on the floor, toilet facilities, and what appeared to be vomit was around the area. The veteran left the area and reported his findings to the VA staff on duty. He was informed that the area would be cleaned. Three (3) hours later when the man left the hospital, the restroom had yet to be cleaned. Mr. Chairman, I don't have to remind you of the diseases which can be transmitted thru such an unhealthy environment.

The lack of sufficient funding and how it affects staffing can affect veterans in other ways. For example: One Medical Center has a Post Traumatic Stress Disorder Ward with a 51 bed capacity. This ward is where the most chronic cases are admitted for treatment and care. Regrettably, only 30 beds are in use and as of March 10, 1989, there was a waiting list of 38 individuals waiting for admission. Keep in mind, these are the truly chronic cases, the ones that should be in the hospital this very minute. Once again, it was indicated that the waiting list existed due to staffing shortages.

In talking with one Hospital Director, he indicated that he had a total of 412 beds. He could, however, operate only 325 and even if the 325 beds were at full capacity, his staff would be stretched to the extremes. Another hospital has 917 beds and is operating only 353. In Philadelphia, a new 240 bed nursing home will be completed this summer. Funds that were set aside for the nursing home had to be used to run the VA Medical Center. When the nursing home opens, money will be taken back from the hospital resulting in additional shortages for the hospital and reduction in services. Even with what funds the nursing home will have, it will not be able to open to full capacity due to staffing shortages within the nursing ranks.

Another area which has been hit hard is the Pharmacy. Pharmacy costs are always a concern to each of the VA Medical Centers. The increased workload and the high inflation for pharmaceutical items have forced Medical Centers to forego purchases of items such as furniture and areas that require renovation to meet patient care needs have been put on hold. Drug refills have been reduced from a six (6) month supply to a three (3) month supply. Prescriptions are filled with generic brands and if a generic brand is not available, the pharmacy may call the prescribing physician and request that another generic drug that gives the same therapeutic result be substituted for the original drug requested. Consideration is also being given to not stocking "over the counter" drugs for out-patient treatment. If this occurs, veterans will be forced to buy their medication on the outside.

In addition to the problems which I have just mentioned, the turn around time for mail-in prescriptions runs from two (2) to five (5) weeks and in some cases, a veteran is mailed medication belonging to someone else. In addition, at all of the hospitals there is usually a one and a half (1 1/2) to three (3) hour delay in filling prescriptions for walk-ins.

Another area of concern is the length of time it takes to be seen by a specialist in a given field after an appointment has been requested. At one Medical Center, there is a six (6) month delay in securing an appointment with the Eye or Orthopedic Clinic. The norm for specialty clinics seems to be approximately three (3) months. At times, appointments are doubled up and, at one facility, morning appointments are scheduled when the doctors are not available until 1:00 p.m. What occurs is that veterans are not seen by a doctor by closing time. On 12/21/88, an incident occurred when the clerical staff knew that the orthopedic doctors would not be available for the entire day. The veterans who had appointments were not told until some five (5) hours later. Whether this occurred due to poor supervisor management, complacency on the part of the employees, or lack of proper staffing is anyone's guess.

Another concern to Hospital Administrators is whether or not their Hospital could pass a review by the Joint Commission on Accreditations. Many VA Medical Centers work closely with local medical schools. These schools demand and deserve to know that the doctors which they produce are trained in a facility which meets the highest of standards. Without proper funding, contracts with these medical schools could be in jeopardy.

In order to meet and work within the budget limitations, many of the VA medical facilities instituted their own program to assist in cutting budgets. The following are examples:

Eg. Perry Point VA Medical and the Coatesville VA Medical Center consolidated their laundry facilities to the Perry Point facility. What has resulted, is lost patient clothing and linen shortages in the Coatesville facility. Supposedly, a remedy for this problem was put into effect on 3/8/89. However, only time will tell.

Eg. Hospitals are referring category B & C veterans to private physicians. The Altoona VA Medical Center has over 400 B & C category veterans on the roll.

Eg. Hospitals will, for non-service connected veterans, bill private insurance, if existent, for any service rendered. The Wilkes-Barre, PA VA Medical Center has established a contract with Blue Cross, Blue Shield, establishing accepting payments rendered. What concerns me most about this is, evidently, the service connected veteran may be targeted next. The following comment was published in the minutes of a VA Staff and Service Officer Meeting on February 23, 1989: "Mr. Parrell had nothing to report on the budget at this time, except to say that there may be cuts for next year, and noted that we have to wait and see what Congress allots to the Veterans Administration for Fiscal Year 1990. As part of the budget to save money, there is talk about reimbursement for services provided to veterans who are 20% and 30% service connected or less, and who have private insurance."

Eg. Oxygen, if needed, is no longer provided for non-service connected veterans upon release from the VA Medical Center as an in-patient. They are required to buy it themselves or have their insurance pay for the oxygen.

Eg. Nursing home placements have been cut from what used to be six (6) month placements to three (3) months at virtually all VA Medical Centers.

Eg. Highland Drive VA Medical Center is admitting only service connected psychiatric patients; all non-service connected psychiatric patients are placed on a waiting list until the Admissions Committee meets each Friday to determine if admission is warranted. This results in non-service connected veterans being committed to state facilities, if available, or left to cope without treatment among the homeless population.

Eg. One Medical Center, in the past, has afforded special mode transportation for the severely disabled veteran if it was indicated in their records (eg. quadriplegics, paraplegics). At this time, the veteran's have been informed that they should seek transportation to the medical facilities on their own.

Many hospitals have already developed or will be meeting shortly to develop contingency plans as to where they will cut service next. Some examples are:

A. Closing Day Treatment Centers
B. Opening a new nursing home in segments
C. Eliminate outside contracts to conduct medical tests which the VA Medical Centers cannot handle (eg. MRI)
D. Further delays in clinic appointments
E. Looking at discretionary categories such as:
   1. Former POW's
   2. WWI or Mexican Border Veterans
   3. Aid and Attendance or Housebound

Mr. Chairman, as you can see, when the VA Medical System faces a budget short fall, as has occurred, the quality of care which the VA is mandated to give to this Nation's veterans is greatly jeopardized.

When a budget deficit occurs in the Veterans Health Services and Research Administration, a domino affect also occurs and results in a decline of timeliness in the Veterans Benefits Administration. This, of course, causes aggravation upon the veteran and a bleak financial outlook. In March of 1988, the turn around time for a rating examination at the Wilkes-Barre VA Medical Center was 62.9 days. This has steadily increased to the point that as of January of 1989, it has risen to 88 days. In the western area of the state, the Erie, Butler, Altoona, Oakland, and Highland Drive Facilities have an average of 47.4 days with the longest delay being at the Oakland VA Medical Center with 63.4 days.

The Veterans Administration Health Care System in Pennsylvania has an awesome responsibility. That is to provide the best quality of service to the 1,508,000 veterans in Pennsylvania. Without your support, the health care system will only decline further and, in the end, this Nation's veterans will be the ones to suffer.

STATEMENT OF
LARRY J. DAWSON
SUPERVISOR, PHOENIX NATIONAL SERVICE OFFICE
DISABLED AMERICAN VETERANS
BEFORE THE
SENATE COMMITTEE ON VETERANS AFFAIRS
April 6, 1989

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

On behalf of the more than 22,000 members of the Disabled American Veterans Department of Arizona and its Auxiliary, I wish to sincerely thank you for giving us the opportunity to present to you our views regarding the situation in the three medical facilities as it pertains to funding and providing of health care to Arizona veterans.

Mr. Chairman, we are being inundated with calls from the three VA Medical Centers from veterans who have had their health care entitlement drastically curtailed, extremely delayed, and, in some cases even refused.

At the current time, we are observing ward closures, clinic closures, loss of ability to provide surgical procedures, and drastic curtailments in prosthetic and sensory aids services. It is clear that the funding deficiencies are contributing greatly to our situation, as is the high influx of winter visitors and the growth of the population in Arizona in general.

Mr. Chairman, we have been in constant contact with the Medical Center Directors regarding these various situations. Since we are discussing the three medical facilities, I will break this down by discussing the individual hospital problems and then those of mutual concern.

The Tucson VA Hospital currently has two ward closures due to previously approved renovation. Another ward which was to have been closed had to remain open due to the fact that the psychiatric care ward was found deficient for adequate treatment purposes. Thereby leaving the psychiatric care ward vacant and in need of massive renovation. The management realizes they have a drastic bed reduction, but do not feel that it will affect inpatient care.

Mr. Chairman, the Tucson VA Medical Center currently has a 41 bed nursing care facility with approval for construction of an additional 120 bed nursing care facility, which they will be breaking ground for in June of 1989, hopefully.

The Tucson facility, through its association with the University of Arizona Medical School, obtains what they believe is a sufficient number of nurses and medical staff. However, they are currently experiencing a distinct shortage of critical care nurses.

Page Two

Mr. Chairman, I previously mentioned population growth of the Tucson VA Hospital. In 1985, they had 150,000 outpatient visits. Those figures increased to 175,000 in 1988. Based on this increase, speciality level clinics have from a four to six month waiting period before a veteran may be seen.

The budget restraints in this hospital have created an equipment problem. At the current time, a ten times greater budget is needed for maintenance and replacement of equipment than what is actually budgeted.

The Phoenix VA Medical Center to date has continued to treat all categories of veterans. However, they are overwhelmed by veterans with legal entitlement based solely on their shear volume. The current outpatient treatment visits at this time have risen to 15,000 per month. This means the hospital is treating 180,000 veterans annually in a space that has been designed for 60,000. This facility should be treating 250,000 outpatients annually. Currently, care is being provided to 6% of the veterans in this catchment area while the national average is 10%.

Mr. Chairman, the space situation has become so bad at this facility at the current time that they have implemented usage of small cubicals for treatment purposes just to try and maintain treatment of the current load. With the increasing population, this situation can only worsen in the next year.

The specialty clinic waiting list at this facility is currently running up to nine months and although the load is ever increasing, the Director of this facility feels they have not "hit the wall" on lack of beds, but still have one ward closed due to inability to adequately staff it.

This facility is experiencing extreme difficulty in obtaining professional health personnel, especially in the area of nursing.

The Prescott VA Hospital is in fair shape as defined by the current Director. However, this facility can more appropriately be described as a long term care facility in that the majority of special level health care needs are currently being referred to the Phoenix and Tucson hospitals. What remaining specialty clinics there are such as dermatology and ophthalmology have anywhere between a three and five month waiting period for appointments. The sad part about this is that the services are being provided by fee basis physicians. The surgical ward has been completely closed. All but minor surgeries are referred to the Phoenix VA Medical Center. There is no psychiatric care unit or dietician on staff at the current time.

Mr. Chairman, this facility currently has one ward that had been closed for renovation purposes. It has been completed, but can not be reopened due to budget restraints and the inability to staff the ward.

In addition, an inadequate budget has prevented the maintenance and repair of other wards, existing clinical areas, and the overall facility.

This facility is trying to reduce its outpatient treatment workload and they have already eliminated non-service connected B & C categories except in emergency situations.

Currently, there is only one surgeon on staff which concerns us in that we see a distinct need for more surgical intervention in emergency situations as opposed to transferring patients to other medical facilities.

Mr. Chairman, on May 19, 1989 a new 60 bed nursing home will be completed. This new building can be expanded in the future to 120 beds. Based on the number of patients immediately available, it should be opened at the 120 bed level. Unfortunately, the facility has no equipment nor funds for staffing to make this facility available for care of those so deserving.

As you know, medical facilities have a minimum and maximum budget to deal with as well as a head count ceiling. Sometimes the diversion of funds will allow help in another area. However, the restrictions on when and how these funds may be divided makes this difficult. It would seem that more responsibility in the management of the hospital should be placed in the hands of its directors as they are normally the best suited to determine where assistance is most needed. All three Center directors have addressed this item as being among their concerns. This, of course, must be done with no disruption of services or provisions of health care to eligible veterans.

Another area of concern was a bonus program for physicians in the past which is due to expire in the next couple of years. A large number of physicians at the end of this bonus era, will have the funds converted into accounting for their final retirement package. When this occurs, we can foresee a potentially large exodus of these physicians.

In closing Mr. Chairman, I do wish to advise you of the continued cooperation and dedication of the medical facility personnel in continuing to provide quality health care under such adverse conditions.

Again, Mr. Chairman, I wish to thank you for this opportunity and commend you and members of the committee for your continued interest and deep concern for America's disabled veterans.

This is the conclusion of my testimony and if you have any questions, I would be more than happy to respond.

PVA
PARALYZED VETERANS
OF AMERICA
Chartered by the Congress
of the United States

STATEMENT OF

RICHARD WOODWORTH

SENIOR NATIONAL SERVICE OFFICER

PARALYZED VETERANS OF AMERICA

BEFORE THE

SENATE COMMITTEE ON VETERANS' AFFAIRS

CONCERNING THE

STATUS OF DVA HEALTH CARE

APRIL 6, 1989

Mr. Chairman and Members of the the Committee, with the soaring deficits facing this Nation, you are being asked to make a very difficult and often unsupported decision: To expend more funds to supplement the Department of Veterans Affairs budget. With the aging veteran population, the demand on the Veterans Health Services and Research Administration is increasing daily. The cost of medical care both in the private and public sector is rising beyond reach, as is inflation for pharmaceuticals, medical supplies and equipment. Directors of Medical Centers, nationwide, have restricted eligibility for health care services to the bone to help make up for this shortfall. Yet the rising cost of medical care in the private sector has sharply increased the demand for care in the public health care systems like the VA, Medicare and Medicaid. All three of these health care systems are

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funded (directly or through supplementations) by the federal government. It is not really a question of DVA funds, we merely increase the burden on the other two federal programs. Veteran for veteran the reduction in demand for services caused by the restriction of eligibility increases the demand on Medicare and Medicaid. Thus, we don't reduce the overall demand for more funds, we merely shift the burden to the federally funded programs in the private sector at a greater expense to the taxpayer.

The average cost of a hospital bed in the Memphis area in the private sector is estimated at $750.00 per day. The cost of one of the most expensive beds in the Memphis DVA Medical Center is $500.00 a day less. If you compare any single aspect of the DVA health care system, the DVA can provide it at less expense to the taxpayer, with just as good quality. Yet, as I intend to prove, by not supplying adequate funding, we not only pay a higher price for the care given through other programs, we are severely sacrificing the quality of the care we still provide to those veterans who actually do get into a DVA hospital. Specifically, these are disabled service-connected veterans, and severely disabled nonservice-connected veterans on aid and attendance. But even they are having trouble getting the services they are entitled to as I have attempted to demonstrate in my oral statement.

Let's turn our attention to the outpatient clinic in any DVA hospital. A service-connected veteran initially spent three to four hours waiting in triage to be seen by a DVA physician. With the demand on the private sector, this is comparable. Now the veteran needs follow-up attention in the outpatient clinic. If a private physician made a referral to a specialist (cardiologist), the average period before he can be seen and receive treatment is usually 15 days. In any cardiology clinic (at least in the following states: Tennessee, Mississippi, Alabama, Arkansas, Oklahoma, Ohio, Georgia, California), you must wait for 45 to 60 days to be seen. That doesn't mean treatment, it's just to have a consultation and diagnosis in the DVA system. Although the DVA could save the federal government a lot of money by treating him within the system, he would normally opt for the private sector if it were not for the medicare co-payment and deductibles. In many cases, some of these veterans will use Medicare, not pay their portion of the hospital bill, which drives up the cost for private medical care for everyone, as the private sector increases their charges to cover their losses. This in turn increases the average Medicare payment annually. The only way to save the federal government money is to direct patients to the most cost-effective health care system we have. Not as many would have you believe, to reduce DVA eligibility and restrict funding. Although, in order to utilize the cheapest health system, we must prevent delays in appointments in all the clinics, Orthopedics, Neurology, Cardiology, Ophthalmology. Additional staff and funding for the Veterans Health Services and Research Administration is our only hope of reducing federal deficits for health care in this Nation.

Pharmacies, like ones at the Nashville pharmacy, do not save the DVA a single penny when they are two weeks to a month behind in filling patient prescriptions because they are short of staff. It costs millions of dollars to treat the diabetics who now require hospitalization because they were without syringes or insulin for a month. It cost the DVA millions of dollars when we don't provide adequate staff to the pharmacies. When we cannot provide maintenance medications to psychiatric patients and we have to admit them to the hospital at a cost of hundreds of dollars per day instead of the nominal cost of the salary of two or three additional FTEE. We pay the cost of not providing funding for personnel in other areas of the Veterans Health Services and Research Administration budget whether we want to or not. In addition, the rate of inflation for pharmaceutical supplies has set a deficit for the Memphis pharmacy for the first six months of FY 1989. The veteran is the one who must suffer the lack of funding in appropriate areas.

Without a doubt, the best view of the fallacy that we save money by reducing funding is without question in the provision of prosthetic supplies. You may think the following is a hypothetical or extremely rare occurrence, but I assure you I see it happening each and every day. Prosthetics in Memphis is $50,000.00 under funded per quarter in fiscal year 1989, as are other DVA Medical Centers, nationwide. System wide, the prosthetics service has one or two alternatives available to them. I assure you they utilize them both. First, they can borrow from one quarter to the next. Then by the last month at the end of the fiscal year, they are out of funds. When this happens, sure they saved $20,000.00 in prosthetics for this fiscal year, but did we save the DVA money? No way! All inpatients who have not received their prosthetics equipment before funds run out are retained in the hospital at tremendous expense to the Veterans Health Services and Research Administration.

The second alternative available to prosthetics is to deny prosthetics items to eligible veterans when they have made a procedural error in trying to obtain the prosthetics device. This is done nationwide. They deny the veteran a "roho" cushion that cost roughly $225.00 in hopes that the veteran does not have representation to assist him in getting the item. If he does have representation, they are able to get the cushion within minutes. However, many veterans will just accept the denial and not make an issue of it. Yes, prosthetics has helped to keep their funding under control for the quarter. Now under either of the above methods, prosthetics has to deny or delay issuing a $225.00 cushion. So even if they save their $50,000 at the end of the fiscal year, have they saved the Veterans Health Services and Research Administration any funds? No! They have only created health problems for the veteran a $65,000.00 expenditure for the DVA in order to care for the veteran's decubiti ulcer. If they are short $50,000.00 per quarter, there is some type of prosthetic equipment that is either being delayed or just not issued. Prosthetics, just like pharmaceutical items, are preventions which we all know are cheaper than the cure.

I deeply appreciate your compassion and concern on behalf of the veterans we represent. If I can respond to any questions or be of further service to the Committee, please do not hesitate to let me know.

VETERANS OF FOREIGN WARS OF THE UNITED STATES

OFFICE OF THE DIRECTOR

STATEMENT OF

THE VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

WITH RESPECT TO

OVERSIGHT OF VETERAN'S HEALTH CARE

WASHINGTON, D. C. APRIL 6, 1989

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

Thank you for the privilege of appearing before you today to express our views with respect to veterans health care. Following are the prepared statements of:

Robert F. O'Toole, Senior Field Representative
Alfred Simmons, Service Officer for Maryland
Robert A. Newsome, Service Officer for Virginia

ROBERT F. O'TOOLE
Senior Field Representative

Mr. Chairman, I appreciate being provided the opportunity to appear before this Committee to testify concerning the current state of the Department of Veterans Affairs health care system.

My name is Robert F. O'Toole. I am the Senior Field Representative of the Veterans of Foreign Wars of the United States, National Veterans Service. My responsibilities include conducting on-site surveys of Department of Veterans Affairs' facilities to determine the adequacy and completeness of services provided to the veteran community. We have six Field Representatives, including myself, who conduct these surveys throughout the United States.

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Our Representatives have observed firsthand the results of the diminishing veteran's health care system. Most of the DVA medical facilities (132 out of 172) were built prior to 1970. Many even prior to World War II. In spite of agency efforts, these aging facilities have not kept up with the advances in modern health care technology. Many, such as the Medical Centers in Prescott, Arizona, and Iron Mountain, Michigan, have x-ray equipment that is 20 to 30 years old.

Almost every medical center has beds or even whole wards closed due to staffing shortages and budgetary limitations. Chillicothe, Ohio, has reported that because they must further reduce their staffing level by an additional 30 FTEE (full-time employee equivalent) they must close down 126 patient care beds units. In Saginaw, Michigan, they have closed 68 beds due to the lack of resources to pay hospital staff. At Wilmington, Delaware, we found that several wards were downsized and consolidated to maintain minimal safe care. In all, 106 out of their 336 authorized beds are out of service. This includes a recently renovated ward that cannot be activated due to their inadequate staffing. At Fort Howard, Maryland, the six-bed Intensive Care Unit was closed due to a shortage of critical care nurses. At Manchester, New Hampshire, we found that many beds counted as vacant were in fact unavailable due to the critical nursing shortage. At the Boston DVA Medical Center, they have 752 authorized beds of which 148 beds are out of service due to on-going construction and another 234 are vacant, 169 of which can be directly linked to their critical nursing staff shortage. This same story can be told about almost every hospital in the DVA system.

The scenarios I have just described directly affect the DVA's ability to provide the quality health care needed by our nation's veterans. Faced with diminished funding and less staffing, most hospitals have reduced not only beds, but curtailed treatment programs as well, such as the Community Contract Nursing Homes Program, Alcohol Halfway Homes Program, Cardiac Care Units, Intensive Care Units, Surgical Service, as alluded to earlier, Community Outreach and many Therapeutic Rehabilitation Programs.

Most medical centers have had to reduce the number of patients maintained on contracts in Community Nursing Homes as well as the time limits on these contracts from six months to as little as 45 days. At Prescott, Arizona, the Residential Home Care Program was closed due to staffing shortages, even though the veterans pay for their own care. The Surgical Service at Prescott was closed notwithstanding the testimony and other information gathered by Senator Dennis DeConcini at a hearing in Phoenix, Arizona, on July 5, 1988, for this Committee. At Boston, the Cardiac Care Unit was closed for construction. They were unable to reopen the unit due to shortage of nurses. Sepulveda, California, on January 3, 1989, closed their 30-bed Substance Abuse Program. Also, at a time when World War II veterans have a high need for Nursing Home Care, this hospital was forced to close 42 of their 200-bed Nursing Home Care Unit. Fort Thomas, Kentucky DVA Nursing Home (a division of Cincinnati DVA Medical Center), has closed 26 of their 206 beds. Newington, Connecticut, closed their 10-bed Alcohol Rehabilitation Program.

Due to many shortages in health care professionals throughout the system, VA medical centers are hard pressed to maintain a semblance of quality of care. To combat this problem and to spread the deficiency equally, the Chief Medical Director recently issued a directive requiring that all medical centers provide inpatient care to no more than 1.5 percent of those veterans in categories considered to be discretionary workload. This directive means that very few category "B" and "C" patients will be treated.

In the routine course of my employment as a Field Representative, I have had an opportunity to discuss the problems facing the medical centers with those in authority. The DVA appears to feel that if you ignore a internal problem long enough, it will go away. Morale is one of these problems. Many medical center Directors will not admit to having morale problems at their hospital.

However, from our surveys we know that with the staffing levels being so low that those professionals remaining must devote more and more time away from hands-on care of patients to perform administrative duties and/or menial tasks; this in turn has an adverse impact on morale. I have talked privately with physicians who feel that the practice of medicine has been set back 50 years in the Department of Veterans Affairs due to many of the personnel reductions. They compared their practice unfavorably to the days of the small black bag and the horse and buggy of yesteryear.

Many medical centers have little or no laboratory coverage during evening and night time hours or on weekends. This seriously degrades the quality of care when test are not given or the results are delayed by hours.

Mr. Chairman, due to the inability of the Department of Veterans Affairs to care for all the veterans requiring their services, many are turned away. I would like to provide the Committee with just four cased that have come to our attention lately, to cite as examples. Due to the privacy act requirements for our representation, I will not use actual names. However, I will be happy to provide this information to the Committee with the understanding that confidentiality will be protected if the Committee desires the names following my presentation.

A category "A" veteran on nonservice-connected pension applied for hospitalization with possible surgery from DVA Medical Center Muskogee about June 1988. After being put off many time, he finally went to a private physican who hospitalized him and had to remove a testicle.

A category "A" veteran who was receiving care for cancer from Muskogee applied for hospitalization for pneumonia on November 20, 1988. He was told to go back home since he was dying of cancer anyway. He subsequently entered a private facility where he died November 25, 1988, from pneumonia and heart complications.

A category "A" veteran with no income applied for treatment of an infection in his foot in November 1988 which was denied. He ended up going to a civilian hospial where it became necessary for his foot to be amputated. Due to no income, the bill was paid by a state agency.

A category "A" veteran suffered a stroke and was rushed to a local Arkansas hospital on January 21, 1989. Due to his serious condition, he was placed on a ventilator. He became ventilator dependent. While the veteran required additional hospital care, the Little Rock DVA Medical Center denied the family's request to transfer the veteran. The Chief of Staff has in place a policy that he will not accept a ventilator dependent patient at Little Rock. Two months later, we have now been informed by the DVA that the veteran is being placed in a Community Nursing Home, at Medicaid expense.

I must ask the question, is this compassionate care?

Reno, Nevada; Loma Linda, California; Allen Park, Michigan, and many other DVA Medical Centers have informed veterans in their primary service area that category "B" and "C" patients are no longer being accepted except in an emergency. Since the law does not require their care, the DVA is looking at this avenue to save money. Veterans were told, by one medical center, to look in the yellow pages for their care at a non-DVA medical center.

What the preceding represents is the general deterioration of the DVA quality health care system.

This has been brought on by many years of decremental budgeting which has not kept pace with the health care inflation rate and an unrealistic productivity improvement reductions by OMB.

This has caused a general malaise within the DVA health care system which has forced them to artificially reduce workload and dangerously cut corners in the care provided to those who make it into the system.

I would like, at this time, to provide the Committee with a number of our medical center surveys which corroborates what I have just stated for the record. I believe the Committee will find them informative and interesting.

This concludes my prepared statement. I will be happy to respond to any questions the Committee may have at this time.

ALFRED SIMMONS
VFW Service Officer for Maryland

Thank you for this opportunity to present the views of the Department of Maryland, Veterans of Foreign Wars of the United States, on medical care for veterans. In this regard, Mr. Chairman, it is of paramount importance for the Department of Veterans Affairs be able to effect a hospital care system that guarantees adequate medical treatment for all veterans. To do anything less would be a breach of the faith veterans have placed in our government.

Through the years, the budget for the Department of Veterans Affairs has not kept pace with the growing need for medical care for an aging veteran population. With the average age of the World War II veteran approaching 69 years, it is logical to conclude that the need for acute and custodial care will increase incrementally.

It would be ideal if the Department of Veterans Affairs would provide medical care to all veterans on demand; however, that is not the case. Budget restraints and cut-backs have reduced or eliminated medical care for certain veterans whose disabilities are nonservice connected. Now these veterans are subject to an eligibility assessment based on annual income because of those restraints and cut-backs.

Veterans in this category are referred to as discretionary care patients. Discretionary care patients are provided medical care on a resource available basis. This includes hospital care, outpatient treatment and nursing home care.

In preparing for this hearing, I contacted the medical centers in Maryland to determine the impact budget restraints had on discretionary care. Fortunately in Maryland, all veterans are being treated on their initial visit to outpatient clinics. Unfortunately, many veterans who require follow-on treatment, hospital care or nursing home care are referred to public and private medical facilities. In all instances, veterans are charged the Medicare deductible if their annual income exceeds the threshold for their category. While this $560 per year may seem negligible for many Americans, it is an unnecessary expense for veterans who expect and deserve to have non-fee medical care.

Mr. Chairman, the problem with discretionary medical care is the uncertainty of who is going to be treated when. The effected veterans cannot afford private medical care. If they could, they would not turn to the Department of Veterans Affairs. Their income is too large for Medicaid and too small to afford medical insurance such as Blue Cross and Blue Shield. These Veterans reach this dilemma in the autumn of their lives when they require the most medical care. This is surely the time the government should do everything within its power to assure that these veterans are not disappointed by the medical care they receive.

Mr. Chairman, this concludes my statement. I wish to thank you and the members of the Committee for holding this hearing, thereby demonstrating your commitment to enhance the provisions of services to veterans by the Department of Veterans Affairs. Thank you.

ROBERT A. NEWSOME
VFW Service Officer for Virginia

Thank you for this opportunity to present the views of the Veterans of Foreign Wars Department of Virginia on medical care for veterans. A senior member of the House Veterans' Affairs Committee said the DVA Budget has a serious shortfall in its health care and construction budgets. He recently visited DVA health-care facilities in all parts of the country and found nurses and doctors worried about whether they will have enough money to carry out their responsibilities.

Category "B" and "C" veterans are being turned away from all the VAMCs in the Commonwealth of Virginia. Also the VAMCs in Martinsburg, West Virginia; Mountain Home, Tennessee; Durham, North Carolina and Washington, D. C.

Cutting DVA health care does not save money. It costs money in the long run.

We are happy to see President Bush will ask for extra money for the DVA for the 1989 and 1990 fiscal years. Secretary Derwinski has asked for $314 million for the 1989 fiscal year and $512 million for 1990. As well as $10 million for more employees and $85 million for construction. We can only hope they are successful. If so, we will be on the way to solving many of the DVA's money problems.

Secretary Derwinski, making his first public appearance since his Senate confirmation, said the Department of Veterans Affairs in the next six months will be restructured in such a way as to serve veterans more effectively and to make it a department of which the veterans will be proud. He said his office will be open to all elected and appointed officers of the service organization because he wants to hear from the Service Officers in the field. He would rather hear from the field than read carefully prepared reports. He wants to hear about every valid problem. I will see that he hears it just like it is.

I know he has discussed with Office of Management and Budget (OMB) the DVA budget and has asked to have direct input in any discussion that involves the DVA Budget. He said we are going to improve programs and get the best out of the system. He places great value on experience and the people he brings in will be quality people.

Current problems are the aging veterans from World War I through Vietnam; the nurses and doctor shortage.

PHANTOM BEDS AND MISSING NURSES

For a number of years now the DVA has misled the veteran public with respect to the number of beds in DVA medical centers which are actually available for the veteran's medical care. While the DVA has managed to provide adequate health care, the capacity of its medical centers to provide health care properly has been stretched practically to the breaking point. The DVA is mandated by law to maintain 90,000 operating beds in its medical system. These beds are needed to provide for the veteran population plus a contingency capacity for the Department of Defense in time of war or national emergency. For reasons known only to certain DVA bureaucrats and a number of budget slashers at the OMB, the DVA has maintained the fiction that it is in conformance with the law. The truth of the matter is; however, those beds simply are not there. There has been reference within the DVA for several years to "phantom beds." Beds officially listed on paper as operating beds to comply with the requirements contained under title 38, USC, but are not actually staffed and available for patient care. Despite official denials, the primary reason for the discrepancy between paper and actual operating beds is the lack of personnel to staff them. This has been borne out through site visits by Service Officers in the field, as well as by other sources. One House Veterans' Affairs Committee staffer visited 16 VAMCs and found 20 percent of the required beds out of service. In hospitals that do have staff shortage leading to closed beds, the average proportion of operating beds which are not adequately staffed phantom beds is 19.1 percent.

At the very heart of this situation is the lack of adequate funding. Using information provided by the DVA, Congress has provided DVA budgets in recent years designed to support slightly more than 194,000 full-time employees. In order to provide adequately for DVA personnel costs, Congress places special emphasis on the tremendous effort and leadership exercised by this Senate Committee in this regard. Personnel funding has consistently exceeded the total requested by the Administration. It is only now becoming apparent medical care funds have gone increasingly to pay personnel cost in order to make it possible for the DVA to attract and retain skilled medical staff in competition with the private sector with special salary rates.

OMB LOGIC

OMB ploy to justify reducing the DVA's health care capability is to cite the relatively low average daily inpatient census--roughly 55,000--for the DVA nationwide. However, with beds officially operating on paper, but actually unusable, it is no surprise that DVA occupancy rates appear to be low. The demand for health care from the DVA by veterans is rising and will continue to rise, and it is this Service Officer's contention that, if there were more DVA health-care beds actually available and operating, the patient census would be considerably higher. By reducing the DVA's actual ability to provide health care and thereby artificially reducing its workload, OMB has fabricated the justification to reduce further DVA health care capability.

The majority of all DVA medical centers are facing a critical shortage in operating funds. DVA hospitals are faced with no further resources on which to draw and will soon be unable to recruit or retain health-care personnel needed to prevent further bed closures and reductions in the ability of the DVA to deliver medical care.

Finally, Congress must provide the DVA with a budget sufficient to meet its obligation to provide the best health care to veterans in a timely manner.

ALAN CRANSTON, CALIFORNIA, CHAIRMAN

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United States Senate

COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, DC 20510-6375

April 3, 1989

Dr. John Gronvall
Chief Medical Director
Department of Veterans Affairs
810 Vermont Avenue, N.W.
Washington, D.C. 20420

Dear John,

As you know, President Bush forwarded a supplemental request to Congress on March 24, 1989, which included $303 million for VA medical care. I am pleased that the Administration requested this supplemental, but I am concerned that the amount requested is insufficient to meet the dire needs of the health-care system.

At the Committee's March 6 budget hearing, Dr. Lewis stated that "we are functioning on the basis that there will be a supplemental available and have borrowed from the fall [fourth] quarter to bring things into the first part of the fiscal year". I have the following questions to which I would appreciate your reply:

1. Would you please provide a breakdown of how the $303 million would be used if appropriated as well as how the $11 million proposed for reprogramming from beneficiary travel (if legislation permitting such a change is enacted) and the $20 million proposed for reprogramming from CHAMPVA will be spent?

2. Will the amount of this supplemental be sufficient to replace that borrowed from the fourth quarter?

3. To what degree will this funding permit VA to increase services to Category B and C veterans, reduce the enormous equipment backlog, maintain the schedule for activations, meet special salary rate obligations, and provide additional resources for contract hospitalization, hospital-based home care, contract readjustment counseling, PTSD treatment, homeless, substance-abuse, VA nursing home, and community nursing home programs?

4. Will the amount of this supplemental be sufficient to restore the FTEE level to 194,720 by September 30, 1989, and, if not, how much additional funding would be needed to do so (and please provide the assumptions underlying such additional amount)?

Thanks for your cooperation and assistance in this matter. I would appreciate a reply by 4 PM on Wednesday, April 5.

With warm regards,

Cordially,

Alan Cranston
Chairman

cc: Honorable Frank Murkowski

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

April 5, 1989

Honorable Alan Cranston
Chairman
Committee of Veterans Affairs
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

This is in response to your request to the Chief Medical Director for information on our plans for the use of the $303 million medical care supplemental request submitted to the Congress on March 24, 1989. I am pleased that the President's request will meet the most immediate medical care needs of our veterans. Prompt action on this request is critical if we are to avoid further decreases in our ability to provide medical care to veterans.

A supplemental appropriation of $303 million will be sufficient to replace the funds which have been "borrowed", as well as to accomplish other objectives.

A VHS&RA plan prepared in early March anticipated an operational allocation of $334 million. If the $11 million becomes available from the reprogramming of beneficiary travel funds and $20 million from CHAMPVA funds, the additional $303 million in supplemental funds will permit this plan to be implemented. A white paper describing this plan is enclosed and responds to your request for a breakdown of how these funds will be used.

The supplemental will not permit any significant increase in services to Category B and C veterans above the level of services now being provided. Without a supplemental, a significant decrease in employment and outpatient workload was anticipated as indicated in the mentioned white paper. The supplemental will negate these reductions, but will not provide for increases in services or employment from current levels. To increase employment to reach 194,720 by September 30, 1989, additional funding of $26 million above the $303 million supplemental would be required.

"America is #1—Thanks to our Veterans"

The supplemental will not reduce equipment backlogs. The current plan without a supplemental projects a reduction below the 1989 budget level because these funds are being used to support employment. That is, the planned reductions of $47.3 million in equipment, $38.8 million in NRM and $46.0 million in activations accounts will be avoided with a supplemental. In addition, the supplemental will permit an augmentation of $32.1 million in activations funding.

Community nursing home care funds will be allocated as described in the white paper. Substance abuse programs will receive special priority for restoration of funds. A portion of the "all other" allocation will be directed toward the readjustment counseling contract program. There are no plans to earmark supplemental funds specifically for PTSD treatment, homeless programs, the VA Nursing Home Care program or the Hospital Based Home Care (HBHC) program. However, VAMC's will have the latitude to review their current operating plans and where appropriate these plans may be revised to include additional support for the HBHC and VA Nursing Home Care programs.

I hope this letter is responsive to your request.

Sincerely yours,

Edward J. Derwinski
Secretary

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
Veterans Health Services and Research Administration

White Paper

FY 1989 Supplemental Action Plan

1. Operationally VHS&RA will allocate the available funds in the following way.

	M - $
o Restore capital accounts "borrowed" to support 190,077 FTEE.	$132,065
o Recurring allotment to VAMC's for Personal Services dollars to increase FTEE from 190,077 to 191,616 cumulative and support outpatient workload.	64,729
o "All Other" costs to support outpatient workload.	28,571
o Increase community nursing home care census.	23,770
o Augment activation account.	32,123
o Allocations to VAMC's to support unfunded needs.	52,496
Total Allocations	$333,754

2. A significant drop in employment, to 186,000 at year end, is anticipated in the current operating plan. When VA Medical Centers are funded $64.7 million dollars in personal services, employment will increase slightly above current levels (approximately 191,300 FTE) and VHS&RA estimates that 191,616 cumulative FTE will be employed. With the additional $28 million in drugs and operating supplies available, the VAMC's will be able to maintain outpatient workload at current levels.

The current and revised plan for FY-1989 outpatient workload are recapped below:

	First Half	Second Half	Total
Current Plan	10,562	9,890	20,452
Revised Plan	10,562	10,832	21,385
Increment	0	+933	+933

3. The passage of a supplemental will enable VHS&RA to fund the capital accounts at budgeted levels and to add $32 million to the activations accounts. Support for current levels of employment ($46 million) and to provide for the unfunded portions of the January pay raise (86 Million) required VHS&RA re-align $132 million from budgeted capital accounts. The 46 million re-alignment came from the activations account and, absent a supplemental, would require a freeze in activations funding in the fourth quarter. By adding $32 million to activations, VHS&RA will be able to augment the $46 million budget and will move toward alleviating some of the significant backlogs in activations. The $86 million re-alignment was made from equipment and NRM accounts. Supplemental funding will permit restoration of these accounts.

4. VAMC's have been permitted to fund the community nursing home care program at levels which are supportable within their overall allocations. Based on these VAMC plans the initial plan was to support 10,709 average daily census (ADC) for this program. Because of budget constraints, VAMC's have fallen significantly below plan, and the current estimate is that existing appropriations will only support approximately 9800 ADC. With supplemental funding VHS&RA will explicitly identify VAMC's where additional outplacements are appropriate and where additional funding will enable these placements. With an additional $23.7 million further reductions will be negated and the program will be able to support an increase in ADC. The level of increase will depend upon when the supplemental becomes available.

5. An additional $52.5 million in funding will be distributed to the Regions to be utilized specifically to support deficiencies in all other funding availability. Each region has identified as part of the budget planning process specific identified all other funding shortfalls. Any available funding not specifically for workload or employment will be utilized to restore these all other funding shortages.

6. All other funding shortages have been identified in drugs and medicines, other contractual services, prosthetics, medical supplies and related areas. The shortages have manifested themselves in reduced formulary items, restrictions on over the counter drugs and supplies, limitations or restrictions on the number of prescription refills, minimal shelf stock, and extended waiting times for prescribed items such as prosthetics. Basic hospital operating needs also need to be restored to satisfactory levels. These include maintenance supplies and materials, linens, equipment repairs services and maintenance contracts.

April 5, 1989
(10A2A)

AMERICAN NURSES' ASSOCIATION
WASHINGTON, D.C.

TESTIMONY

of the

AMERICAN NURSES' ASSOCIATION

Before the

SENATE COMMITTEE ON VETERANS AFFAIRS

APRIL 6, 1989

1101 14th STREET, N.W., SUITE 200, WASHINGTON, D.C. 20005 — (202) 789-1800
FAX # (202) 842-4375

The 188,000 members of the American Nurses' Association (ANA) and its 53 constituent state nurses' associations, the approximately 40,000 registered professional operating room nurses who are members of the Association of Operating Room Nurses (AORN), and the 60,000 registered nurse members of the American Association of Critical-Care Nurses (AACN) appreciate the opportunity to address the impact of the budget on veterans' health care. A significant number of ANA members are Veterans' Administration (VA) nurses. In addition, ANA has represented VA nurses in collective bargaining since 1967 through its state nurses' associations.

Our message is clear -- all is not well in VA hospitals. In fact, if the VA health care system were a patient, we would describe its condition as "critical." There is no doubt that this condition will deteriorate if meaningful measures are not taken.

This hearing reflects the committee's continued commitment to the provision of quality health care for the men and women veterans of our nation. The committee has been instrumental in improving working conditions for nurses; guaranteeing nurses the right of collective bargaining; encouraging nursing career development; providing educational opportunities; promoting clinical nursing research; and fostering the critical inclusion of nursing within the Veterans' Administration health care system. The committee has also stressed the inclusion of women veterans within the VA programs. Those policies have done much to ensure quality nursing care for all veterans. It is our hope that the committee will continue to hear the needs of the patients and health care personnel so that we may improve not only the quality of care rendered to veterans but also access to the health care system.

The ANA has endorsed the budget recommendation submitted by four veterans groups entitled, "The Need Is Now." An Independent Budget by Veterans for Veterans Programs. We are concerned that the President's proposed Fiscal Year 1990 (FY 90) budget for the VA continues a downward trend in the necessary levels of monetary support for health care and research. This is occurring at the same time the VA is facing an influx of older and sicker patients. These veterans are more seriously ill. Their care is complicated by factors of age, the presence of chronic illnesses affecting many body systems, the use of highly technological treatments, pressures for early discharge, and the rapid increase in the number of patients with acquired immune deficiency syndrome (AIDS).

The needs of patients in today's health care system require the care of a registered nurse (RN). The surging demand for nurses, a major factor in the national nursing shortage, provides evidence that efficient, effective utilization of qualified, experienced RNs is needed to preserve quality of care within the limits of cost containment. Unfortunately, this increased demand occurs during a nursing shortage crisis experienced throughout the public and private health care arena.

Years ago, VA hospitals were in the forefront with respect to nurses' salaries, benefits, and educational and professional development. However, as the private sector responded to changes in reimbursement, patient acuity, and health care manpower concerns, the VA has been unable to compete. The private sector can respond to market demands without any delay, but the VA is subject to the appropriations process and budget restrictions. Nowhere is that more evident than in nursing recruitment and retention. In Pennsylvania, for example, we are told that VA hospitals have no budget money for recruiting nurses. In fact, the nurses themselves, feeling the strain of the nursing shortage in their work situation, have had to raise money for recruitment efforts. We are concerned that where the VA once led the way in research and innovative clinical programs, budget reductions will impede the development of new care approaches.

It is especially important that the VA's advances in geriatric care and gerontological research and education not be curtailed. Additionally, as the numbers of aged veterans and those requiring long term care (patients with head injuries and HIV infection) increase, we must have adequate nursing homes and manpower to provide quality health care.

As a result of FY 89 budget restrictions, we have already seen veterans' access to health care adversely impacted. Many VA's have closed beds and units due to the inability to supply nurses; other VAs are examining their specific mission which may limit veteran access. Additionally, clinics in Chicago have been told to discharge stable patients and only service-connected patients can be followed indefinitely. Community follow-up is questionable. There is no money to pay for travel expenses of patients so that they can keep their appointments for follow-up care. In one case, an indigent patient suffering from Chronic Obstructive Pulmonary Disease had to walk four hours to his VA out-patient clinic because travel money was not available. Another patient had to undergo a three month wait for an appointment regarding a service-connected disability.

Budgetary reductions have also resulted in a reduction in nurse mix in several VA medical centers; in some, a 50 percent correction (staff reduction) has been ordered. Nurses from Illinois and California VA hospitals report freezes in employment of RNs, licensed practical nurses (LPNs), and licensed vocational nurses (LVNs). The Illinois Nurses Association reports that one VA hospital has 20 nurses on waiting lists for hire because the hospital cannot foresee a ceiling for RNs because of budget uncertainties. In Region 6, several hospitals, including Livermore and Reno, reduced their RN ceiling in FY 88 in anticipation of the FY 89 budget restrictions. How can we justify hiring freezes on VA nursing personnel and reductions in nurse mix, when there is an extreme nursing shortage within the system?

The freeze has also meant that in Illinois' Westside clinic, RNs were rotated to the emergency room with no orientation, even though many of them did not have the requisite skills for emergency care duty. Similarly, medical-surgical RNs in the Martinsburg, West Virginia facility have to float to oncology units without sufficient orientation. In one California facility, the position of the infection surveillance coordinator has been reduced to a 0.5 full time employee equivalent (FTEE) level, and the coordinator must share evening administrative nurse on-call duties. This is occurring while private sector infection control practitioners are reporting an increase in their workloads in response to the development, implementation, and compliance with occupational health standards for blood-borne diseases such as hepatitis B and HIV infection.

Nurse managers have been instructed to increase non-RN staff to make up for RN reductions. However, VA medical centers report high LPN/LVN vacancies and turnovers, and reductions in LPN/LVN ceilings. The VA cannot employ adequate numbers of LPNs/LVNs because they cannot compete with the private sector. This decrease in RN mix also means that the VA will have to utilize increasing numbers of lower skilled employees to provide health care to veterans. It may also mean that veterans may be deprived of essential life-preserving care and treatment. In North Chicago, the Illinois Nurses Association reports that if the chemotherapy nurse is on leave or ill, there is no replacement; therefore, no chemotherapy is provided.

Budget reductions have also apparently had an impact on the ability of some VAs to provide surgical services to veterans. Reportedly, one VA's surgical suites were in such poor condition that surgeons could not utilize them even after new advanced equipment was received. In addition, an adequate number of appropriately trained staff was not available. The operating room nurses in the Martinsburg's VA are required to float to the medical-surgical units. The Lexington, Kentucky VA has had two nurse anesthetist vacancies for some time. Both these situations may limit scheduling of surgeries.

The proposed budget will provide no funding for the revision of RN pay scales. As pointed out in the document "The Need is Now", $400 million must be appropriated to maintain the same level of RN staffing in FY 90. Those funds must be provided in full and up front, in order to eliminate the occurrence of serious shortfalls. Previous shortfalls have resulted in staff cutbacks and corresponding reductions in needed services for veterans.

Existing shortfalls will result in a reduction of more than 100 RNs in the northeast region. Those numbers do not include nursing assistants, whose cuts could be equal to or more than the RN cuts. The mid-atlantic region has been instructed to reduce RN ceilings by 76 and LPN/nursing assistants by 25. Those facilities that have not reduced their staff will be required to do so in the future. Additionally, reductions in clerical, pharmacy, and respiratory therapy positions will mean additional duties for RNs.

Decreases have occurred in funds for education programs, and no funds are available for the replacement or repair of equipment. Educational literature for substance abusers cannot be furnished. Low supply levels mean that veterans' care and treatment are delayed, if outside purchasing cannot be expedited. Even basic medication is not available. The VA medical care program cannot continue to absorb the costs of pay raises and special pay. Congressionally mandated funds for personnel costs must be provided. We cannot continue to rob Peter to pay Paul when neither are adequately funded to meet veterans' health care needs.

Finally, and most importantly, we believe the VA's ability to provide quality care to veterans comparable to that offered in the private health care sector is critically compromised by the VA's inability to compete with the private sector's recruitment and retention programs for nurses. Although this committee and the agency have done much to facilitate VA competitiveness, much more needs to be done. We wholeheartedly advocate a change in the restrictive civil service pay schedules. Nursing staff and support salaries must be increased; at least 3,000 beds are reportedly closed due to nursing shortages. The VAs in Cincinnati, and Louisville and Lexington, Kentucky have hired nurse recruiters to combat the nursing shortage. The VA no longer leads the way with benefits such as salaries or retirement packages. Nor has the VA been able to supply the necessary computer assistance for nursing, as many hospitals in the private sector are doing.

We must reiterate that the FY 90 VA budget is insufficient to meet current services. However, if the reports we have heard are reflective of the impact of the FY 89 budget, those funds are sorely inadequate to assure quality health care provision to the nation's veterans. This means future shortfalls and further reductions in health care services to meet the demands of an inadequate budget.

Thank you for the opportunity to address veterans' health care. We will continue to work with Congress and the VA to provide the nurses necessary to operate the VA health care system. We pledge nursing's support in implementing the programs and changes necessary to respond to the present and future health care needs of today's and tomorrow's veterans.

STATEMENT OF RICHARD S. CHRISTIAN, DEPUTY DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE COMMITTEE ON VETERANS AFFAIRS
UNITED STATES SENATE
APRIL 6, 1989

Mr. Chairman and Members of the Committee:

The American Legion is appreciative of this opportunity to express its views concerning the present state of veterans' health care within the Veterans Health Services and Research Administration (VHS & RA).

Mr. Chairman, at the hearing before this Committee on September 9, 1988 concerning funding shortfalls and management challenges facing the Department of Veterans Affairs (VA), specifically with regard to health care services, The American Legion raised serious questions and concerns about the fiscal distress at VA medical centers. We identified a series of problems across the country at that time which included bed closures, curtailment of certain treatment programs, reduction of treatment to nonservice-connected veterans, excessive waiting times for admission to hospitals and for appointments in certain outpatient clinics. The initial distress signals reported by our Department Service Officers and National Field Representatives of the significant degradation of resources have now been confirmed by The American Legion's survey of VA medical facility directors.

As we have previously advised the Committee, because of our concerns about the reported funding shortfall faced by VA medical care facilities, The American Legion has undertaken a survey of every VA medical center, wherein we secured information on the impact of the current funding shortfall and staffing problems. All hospital directors have completed the survey and returned it to us. At the present time we will provide some summary highlights of information obtained thus far.

All 159 VA medical center directors have taken the time to respond to the survey questionnaire. We value their comments and the extensive amount of data they provided us. We share this information with the Administration and the Congress to better serve this nation's veterans.

A summary of The American Legion survey reveals that:

* The vast majority of respondents reported affirmatively that they would implement discretionary workload reductions in both inpatient and outpatient care. Of 159 facilities responding, 135 have indicated limited access to health care will be provided to Category B and C veterans. This limited care primarily constitutes emergency treatment and perhaps a modest medication supply. Approximately 20 facilities have reported a similar reduction of services to Category A, nonservice-connected veterans. It appears most facilities are attempting to hold the line on reducing services to Category A nonservice-connected clientele. (However, it is our prediction that once the fourth quarter of this fiscal year commences, Category A nonservice-connected veterans may also be subjected to discretionary workload reductions, without the provision of a FY 1989 supplemental medical care appropriations).

* A significant number of respondents, 72 facilities, have reported delays in providing specialty clinic appointments. These delays extend across all categories of beneficiaries.

* Veterans are being terminated from outpatient clinic rolls to help stations support needs in other areas of direct patient care.

* A total of 113 facilities have reported reductions in funds for contract nursing

home care. Generally, through a reduction in the length-of-contracts and the contract census, facilities are using funds designated for this program to offset other budgetary shortfalls.

* Elective surgery delays were reported by 85 facilities.

* The following number of facilities have reported pharmacy service reductions in each respective area:

Prescription Refills	- 75
Mailout Program	- 45
Over-the Counter Drugs/Supplies	- 97
Formulary Reductions	- 101

* A total of 133 facilities reported deficits in Non-Recurring Money (NRM) funding for maintenance, equipment and supplies. The accumulated deficit for FY 1989, by category,is as follows:

Equipment and Supplies	- $188.6 million
Maintenance	- $146.3 million

* The reported number of hospital beds closed since July 1, 1988 for budgetary or recruitment related reasons is 2,652.

* Various program reductions in direct clinical care have been enacted or are being contemplated in a large number of VA medical centers. Additionally, a complete program review of facility missions is presently underway in the VA central office to

study potential cost savings through local mission changes.

* Morale among facility managers and staff physicians is being seriously challenged due to the myriad of cost constraints affecting the delivery of basic health care services. From the simplest to the most complex health care available within VA medical centers, virtually no area has not been affected by the present fiscal crisis. The Chief Medical Director has decentralized decisions relating to which programs and services may be reduced and, consequently, access to care may be uniform throughout the system, however, the particular services veterans may receive are not. If the present trend of decremental funding continues, the VA could stand to lose a large number of highly dedicated health care personnel.

In addition to information obtained directly through our survey questionnaire, several succinct examples of problems being reported by our Department Service Officers are as follows:

* VAMC Iowa City, IA would not recognize a former POW's nervous disorder or determine service connection. He was being treated for awhile but now has been cut off from treatment because he was not service-connected.

* VAMC Iowa City, IA discharged a nonservice-connected veteran with active pneumonia and a heart condition. He has since entered a civilian hospital.

* VAMC San Diego, CA denied five World War I veterans treatment on the basis of income.

* VAMC Sioux Falls, SD terminated a veteran (Category B) on a home dialysis

machine, from the outpatient rolls.

* VAMC Sioux Falls, SD would not honor a prescription for a veteran with a kidney condition who was service-connected and subsequently developed high blood pressure. A special medication was prescribed but the pharmacy did not carry the drug because it was too expensive and offered him a substitute which was not suited to treat his condition.

* VAMC Lexington, KY turned away 136 Category C veterans in a two month period. The Louisville VAMC, through proper management of resources and the scheduling of additional outpatient clinics, has turned no Category B or C veterans away.

The reports that we are receiving about problems with the provision of veterans health care go on and on.

The Administration has recommended a FY 1989 supplemental appropriation of $303 million, which is less than originally requested by Secretary Derwinski, for the medical care account. Further, as this Committee is aware, Secretary Derwinski requested an amendment to the FY 1990 proposal for an additional $512 million and 5,093 medical employees, as well as an additional $85 million for major medical construction prior to his confirmation. This amount of additional funding would not alleviate the existing problems, although it is a step in the right direction.

The purpose of this statement is to enlighten the Committee as to the findings of our survey of medical center directors, and to reemphasize the need for additional medical care funding - immediately.

The American Legion cannot urge the Committee strongly enough to closely examine this critical situation, and to act accordingly, before the erosion that is taking place in the medical centers leads to the total deterioration of the VA medical care system.

That completes our statement Mr. Chairman.

THE AMERICAN LEGION SURVEY OF DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER BUDGETARY STATUS FOR FISCAL YEAR 1989

INTRODUCTION

During the month of November 1988, The American Legion initiated a comprehensive survey to identify each Department of Veterans Affairs Medical Center's (VAMCs) projected Fiscal Year (FY) 1989 budgetary shortfall and to determine the impact of the funding shortage on the delivery of health care services to veterans. Survey forms were mailed to all 172 medical centers (including two-division VAMCs). Medical center directors were asked to identify various program shortfalls projected for FY 1989 and to determine the amount of funding that would be required to provide services at the same workload levels experienced during FY 1988. Specific questions were included relating to staffing, pharmacy, outpatient clinic waiting times, deficits in maintenance, equipment and supplies, and others. A standardized survey form was used so that similiar information would be gathered from all VAMCs. The survey form used, and the covering letter are attached.

METHODS

Questionnaires were mailed to all medical center directors requesting candid responses because of the fact that the information is vital to the future of the veterans health care system. Questions were developed from common concerns identified through hospital survey visits conducted by American Legion National Field Representatives over the preceding several months, and through input by our Department Service Officers.

The American Legion does not claim that this survey is an exact study. Specific questions selected were chosen from a composite of identified VAMC funding concerns. The information obtained was provided by VA field level management personnel, and is for the most part considered to be reliable.

DISCUSSION

Of 159 survey forms mailed, a total of 159 responses were received. This figure represents a 100 percent response rate. These 159 VAMCs have been separated into two distinct categories: small to non-affiliated (under 20 residents); moderate to highly affiliated (over 20 residents). There are 70 VAMCs in the small to non-affiliated category and 89 in the moderate to highly affiliated category.

In the small to non-affiliated category, of 70 responses, 65 VAMCs reported significant medical care budget deficits. The average FY 1989 budgetary shortfall reported by these facilities is $806,000.

In the moderate to highly affiliated category, of 89 responses, 83 VAMCs reported significant medical care budget deficits. The average FY 1989 shortfall reported by these facilities is $2.51 million.

Unfortunately, there is some discrepancy in the information reported by a small number of medical center directors. The most obvious of these are a number of medical centers with no reported funding shortfall, where it is stated that workload restrictions are being implemented and nursing home contracts are being reduced.

As previously mentioned, all 159 directors responded to the survey, and of those 143 reported FY 1989 funding shortages in specific amounts, 11 reported no current year shortfall, and 5 reported funding shortages but did not specify the amount. For the latter 5 facilities, deficits were projected, based on average amounts reported by affiliated and non-affiliated VA medical centers.

There will be further examination in those instances where it was reported that there is no funding shortage.

RESULTS

The reported FY 1989 funding shortfall is having a wide ranging impact on veterans' accessibility to VA medical care. Due to significant shortfalls in medical care funding for FY 1989, top VA policy officials have implemented a strategy of ensuring that veterans have equitable access to medical care across all VA geographic regions. To accomplish this goal beginning in FY 1989, each medical center is permitted to treat up to a maximum discretionary workload of 8.3 percent for outpatients and 1.5 percent for inpatients. Essentially, the amount of funding expended by individual VAMCs is not permitted to exceed these discretionary workload levels. Over a three year period the VA has projected a workload reduction of 541,000 outpatient visits and 10,000 fewer hospital discharges as a result of this policy.

Several flaws in this strategy were identified through information obtained from this survey.

Hospital Care

Based on this survey, it appears obvious that workload reductions that the VA had planned to achieve over a three year period will be realized in a far shorter time period. Hospital officials are reporting a projected workload reduction in the Category B/C outpatient level of upwards of 500,000 visits just in FY 1989. Since there is no projected real increase in outpatient care funding during FY 1990, it can be proposed that more severe reductions in the outpatient discretionary workload will occur than initially predicted by VA policy makers. Additionally, many VA hospitals reported that the Category B/C workload reduction will yield little savings (on average about 5 percent in ancillary costs) and the discretionary workload reductions will be offset by increases in the nondiscretionary workload category. Insufficient information was provided to determine the accuracy of the VA's inpatient workload reduction projection of 10,000 fewer discharges over a three year period. However, if as reported most VAMCs reduce their discretionary workloads by roughly 5 percent, equal to the total Category B/C workload percentages nationwide, it can then be projected the initial workload reductions estimated by the VA will be exceeded much sooner.

The following chart shows the number of VAMCs responding to the following questions:

	Category A (NSC)	Category B	Cateogry C
Outpatient workload reductions expected	16	125	135
Inpatient workload reductions expected*	16	87	100

*Will provide only emergency services.

In addition to restricting access to outpatient Category B/C veterans, 62.8% of the VAMCs reported that only emergency inpatient services would be provided to the same category of veterans.

Delays in obtaining specialty clinic appointments were reported by a number of VAMCs (45.2%). The length of these delays extends across all categories of beneficiaries and ranges from 2 to 12 months for initial appointments. Primarily, orthopedics, urology, cardiology, compensation and pension examinations, ophthalmology, and others are included in these delays.

Activation funding for new programs and/or the activation of new construction, i.e., outpatient clinics, spinal cord injury units, nursing home care units, and clinical additions has been delayed due to a lack of available resources. In fact, funding which had been earmarked to activate these programs in FY 1989 has been diverted to personnel accounts so that health care salaries can be paid.

Contract Nursing Home Care

One of the hardest hit programs in FY 1989, according to the survey, has been the Contract Nursing Home Care (CNHC) Program. A majority of VAMCs (71.0%) reported severe reductions in funding to support this program. Approximately 75% of the amount of resources previously applied to this program have been diverted to cover other operational shortfalls in the medical centers.

Since the VA is authorized to provide up to a six month contract for community nursing care, and a minimum of a three month contract (M-1, Part-1, Chapter 12, Change 2, dated 2/18/88) for nonservice-connected veterans, the 20 VAMCs which responded that they are providing less than a three month CNHC contract appear to be in violation of the VA's own standards.

Approximately 12 VAMCs reported that no CNHC contracts are being provided to NSC veterans and they must obtain community nursing care at their own expense.

In addition to the reduction in the length of CNHC contracts, 45 VAMCs reported a reduction in the average number of veterans included in the program.

Surgical Care

Emergency surgical care was reported as being provided in a timely manner. However, a major problem identified was the extent to which elective surgeries are either postponed or totally cancelled. According to survey responses, 85* or 64.3 percent of the VAMCs reported having to postpone or cancel elective surgeries. This is extremely disturbing as it means that veterans who must use the VA system cannot be assured a timely appointment for surgery, or that it will be accomplished at all.

* 27 of the VAMCs surveyed do not have an inpatient surgical service.

Pharmacy Service

In looking at pharmacy services at VAMCs the following reductions were reported:

Reductions in Services	
Prescription Refills	47.1% or 75 VAMCs
Pharmacy Mailout Program	28.3% or 45 VAMCs
Over-the-Counter Drugs	61.0% or 97 VAMCs
Fee Basis Formulary	63.5% or 101 VAMCs

There has also been a significant reduction in the number of drugs maintained on VAMC prescription formularies. This action is supposed to be primarily a cost savings measure. In all of the identified categories of reductions, the primary beneficiaries affected include the discretionary workload. The reduction in formulary prescriptions affects the service-connected and nonservice-connected veterans equally.

Reduction of Hospital Beds

Since the middle of 1988 when a House Veterans Affairs Committee survey showed 13,039 VA beds were out of service nationwide, a significant number of acute and extended care beds have additionally been closed. The primary reasons given for this have been budgetary and recruitment related.

Essentially, a reduced number of entry point admission beds creates havoc in some medical centers and is not demonstratably a problem in other areas. However, it is obvious that a significant reduction of available admission beds does create problems and inconveniences for the veteran patients. The total number of hospital beds closed for various reasons since July 1, 1988, as reported by the hospital survey is 2,652. The breakdown of these beds is as follows:

Medicine & Surgery	1,883
Intensive Care	36
Acute Psychiatry	336
Alcohol Treatment	172
Nursing Home Care	225

Non-Recurring Money (NRM) Shortfalls

Included in this category are funds for VAMC local level construction projects, equipment purchases (new and replacement), and supplies.

During FY 1989, VAMCs have been instructed not to divert appropriated funds from these accounts to cover other operational shortfalls, as occurred during FY 1988. Thus, the following data will report the amount of NRM shortfalls reported for FY 1989, in terms of operational deficits. We cannot determine at this time if any NRM funds will be diverted to other operational accounts during FY 1989.

FY 1989 NRM SHORTFALLS AS REPORTED

Maintenance	$146.3 million
Equipment and Supplies	$188.6 million

OTHER SIGNIFICANT CONSIDERATIONS

It is impossible for this survey to determine the full impact of FY 1989 budgetary shortfalls on the delivery of VA health care services. In addition to the previously reported information, other budgetary problem areas were highlighted through survey responses. The most significant of these are:

- The deterioration of academic and research activities.

- Hospital employment levels are being further reduced due to a shortage of salary dollars and due to an inability to compete for scarce medical and ancillary personnel, as a result of noncompetitive wages and benefits.

- Current hospital programs, in addition to new clinical initiatives, are being cut back or eliminated. Inpatient and outpatient psychiatric programs are being reduced, cutbacks in dialysis care are becoming commonplace, reductions in contract medical programs, such as CAT scans and Radiation Therapy have taken place, prosthetic orders have been increasingly delayed, and the list of clinical service reductions continues to grow.

- Primarily, the non-mandatory workload, Category A nonservice-connected, and Category B/C veterans are incurring the greatest amount of difficulty because of the VA's budgetary shortfall. The time required to schedule new outpatients has continued to increase for mandatory workloads. Also, delays in obtaining specialty inpatient procedures, such as orthopedic surgery, and special ambulatory care procedures, affect all categories of veteran beneficiaries.

SUMMARY

The survey's results compiled from December 1988 through March 1989 confirm that substantial budgetary shortfalls are having a considerably negative impact on the ability of medical centers to provide a full range of services to eligible beneficiaries.

The VA is currently targeting the majority of its medical care resources toward meeting the health care requirements of the mandatory veteran workload. Veterans who are not listed as Category A service-connected are bearing the brunt of the budgetary shortfall. Even within the "entitled" group of veterans, delays in obtaining health care services are occurring. Several comments made by hospital directors suggest that even if the VA were obligated to treat only the mandatory veteran workload, there would still be a significant overall medical care shortfall. This suggestion is supported by the reported deficits in employment levels, equipment and supplies, and local level maintenance funding. It is much more difficult today to obtain necessary health care services (albeit non-urgent care) if one is considered part of the discretionary workload than it was five years ago, even though Congressional appropriations for VA medical care have increased somewhat. This phenomenon is due to a number of issues, to include an increasing aging veteran population, the introduction of the means test (through the categorization of veteran eligibility), a decreasing medical care appropriation (in actual dollars), and a myriad of other factors.

Based on survey responses, it appears the VA will achieve its objective of a 541,000 outpatient visit reduction in a far shorter period of time than the three years initially forecast. It is conceivable that 500,000 outpatient visits will be eliminated in FY 1989 alone, due to newly imposed Category B/C veteran restrictions. Additionally, program closures and cutbacks are affecting the ability of nonservice-connected veterans to receive necessary medical care, such as alcohol and drug treatment programs, nursing home care, hospital based home care, and others.

An example of the comments offered by hospital directors regarding the existing budgetary dilemma is expressed through a direct quote provided by one individual:

"All of our executive staff continues to be more than willing to accept their management accountability and responsibility during these formidable times of resource constraints and uncertainty. However, it is increasingly evident that our managerial skills, commitment to our mission and ability to develop innovative solutions is insufficient to cope with decremental budgets.

"The staff is frustrated, demoralized and impatient; the patients and the veteran service organizations are confused and exasperated; the relationship with the affiliated medical school is eroding; and we are experiencing intractable problems in the recruitment and retention of key staff. This milieu is having and will continue to have an adverse impact on the quality of patient care".

The American Legion
For God and Country

▼ WASHINGTON OFFICE ▼ 1608 K STREET N.W. ▼ WASHINGTON [illegible]
[illegible] ▼

November 23, 1988

Dear:

The American Legion has, for many years, gathered a significant amount of facts and statistics relating to individual Veterans Administration medical care facilities and the system as a whole, through site visits by our National Field Service Representatives. This information, including important budgetary data, has provided us with first-hand facts on which to base our efforts to defend the veterans' health care system in America, and our recommendations for improvements in the medical care program.

However, because of the cyclical nature of our individual site visits - which are currently being carried out on approximately a biennial basis - we do not currently have up-to-date information on the impact of the ongoing budgetary dilemma on each of the VA medical facilities.

The Administrator's office has been told of this project.

Because the information we seek is vital to the future of the veterans' health care system in this country, we appreciate your cooperation in completing the enclosed survey and returning it to the undersigned at the above listed address. If you have any questions or comments relating to the survey, please do not hesitate to call me on (202) 861-2752, or FTS 373-3417.

Sincerely,

JOHN F. SOMMER, JR.
Director
National Veterans Affairs and
Rehabilitation Commission

Enclosure

AMERICAN LEGION SUPPLEMENTAL VA MEDICAL FACILITY SURVEY

Questions for Hospital Management

1. For the recently concluded fiscal year (1988), what cost centers within medical center operations encountered the greatest funding strain? Please identify.

2. What is the projected medical center budgetary shortfall for fiscal year 1989? What workload reductions are anticipated in FY 1989 due to budgetary shortfalls? Please explain.

3. What station level policy changes will be required in order to remain within the projected FY 1989 workload estimates?

4. What number of FTEE reductions will be required during FY 1989, relative to the previous year's level? Please identify 'Target Allowance' and 'Productivity Reductions' separately.

5. What was the percentage of the following workload categories treated by the medical center during FY 1988? Please include combined medical center/outpatient clinic totals, if applicable.

Category A. (SC)
______________________ %

Category A. (NSC)
______________________ %

Category B.
______________________ %

Category C.
______________________ %

6. What particular categories of patient eligibility will be subjected to anticipated workload reductions during FY 1989? How much real savings are expected as a result of the workload reduction? Please explain.

7. Are outpatient clinic scheduling times increasing, especially for the Category A service-connected workload? If yes, report the length of time of the increase and any other outpatient scheduling problems.

8. Are eligible veterans being dropped from the outpatient clinic rolls, without regard to the ability to receive community care? If yes, what specific categories of ailments are not being seen.

9. Are scheduled elective surgical appointments increasingly being delayed or cancelled, with particular reference to Category A service-connected veterans? If yes, report the timeframe or reasons for cancellation.

10. Have any additional ward or bed closures occurred due to budgetary or staff recruitment concerns since July 1, 1988?

11. Have there been or is it expected that any reduction in services in the following categories will be required due to budgetary restrictions?

A. Prescription refills

B. Pharmacy mailout programs

C. Over-the-counter drugs

D. Fee Basis eligibility

12. Have nursing home contract placements been curtailed or the length of the contract reduced - for example, from six months to 2 or 3 months? If yes, please provide the details.

13. What amount of accumulated deficits have been incurred in the categories of non-recurring maintenance, equipment, and supplies, during the timeframe FY 1988-89 (please include FY 89 projection).

FY 88

FY 89

14. Have you had difficulty in filling vital personnel positions due to resource constraints, in addition to recruitment difficulties? If yes, please provide significant examples by FTEE category.

MD

RN

LPN/LVN

Pharmacist

Technologist/Technician

Other

15. Any additional comments that you would care to make will be appreciated.

NAME:

POSITION:

MEDICAL CENTER:

NOVA NURSES ORGANIZATION OF THE VETERANS ADMINISTRATION
6728 Old McLean Village Drive
McLean, Virginia 22101
Phone (703) 556-9222

Statement of
Claudette Morrissey, RNC
President,
Nurses Organization of the Veterans Administration (NOVA)

Before the

U.S. Senate Committee on Veterans Affairs

April 6, 1989

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Mr. Chairman and Members of the Subcommittee, I am Claudette Morrissey a Registered nurse employed full-time as a Staff Nurse at the Veterans Administration Medical Center, Brooklyn New York. I am here today as President of the Nurses Organization of the Veterans Administration (NOVA) and I thank the committee for the opportunity to appear before you. While I speak as the representative of NOVA, it is my goal to address the needs of the veteran patients cared for by over 32,000 RNs in the 172 VA Hospitals and 200 outpatient clinics. NOVA is most concerned about the adverse effect on veteran health care of the proposed 1990 VA Medical Budget and the uncertainty of the request for a supplemental appropriations for our present fiscal year.

The Administration's proposed budget, coming on top of the shortfall and the shortages we are presently experiencing seems like a cruel joke at the expense of veteran patients and the dedicated professionals who care for them. The hearts and consciences of VA nurses are touched daily as nurses strive to provide quality care on a timely basis to the veteran patient who seeks and deserves that care. We cannot believe that budget reductions of 8,957 total FTEE are being considered with full knowledge of the current desperate patient care situation.

Patient Care

From the perspective of the health professionals working on the front lines the budget cuts and shortfalls and workload adjustments of the past are having a very immediate human impact. The decreases in FTEE and increases in productivity, mean that Registered Nurses giving care in the field are exhorted "*to do more with less.*" We already do more with less because of the historic low staff to patient ratios in the Veterans Administration Hospitals. There are not sufficient numbers of VA nurses to fulfill the VA mission of quality care, nor are there sufficient numbers of nurses to consistently provide adequate or safe care.

The ability to provide patient care is severely compromised when there are not enough nurses. Nurses know this in our minds and hearts and don't expect others to believe our instincts but we do expect them to believe our data. In VA hospitals we can document this daily by using a patient classification system. This system quantifies the minutes or hours of care patients with certain needs require. The number of hours of staff time available should be equal to the total number of hours of care needed by the patients. Nurses tell us the numbers just do not add up
It is common that the number of hours of patient care far exceeds the number of staff hours available to provide the care. When this happens patients do not get the care they require. As one head nurse on a surgical unit reported, "*When I don't have enough nurses my post-operative patients run fevers because we don't have the staff to get them coughing, deep breathing and sitting up.*" Other examples of omissions of patient care include greater numbers of patients developing bedsores when staffing is not adequate to provide frequent turning in bed, compromised nutrition when patients are not fed in a timely manner and the food gets cold, medications missed due to the great number of patients assigned to one nurse and documentation of patient progress and response to treatment are omitted on a daily basis.

When nurses experience this excessive workload we are working so fast that we fear we will make a serious life-threatening mistake or that we will not be available to observe when a patient's condition changes for the worse. Many nurses entered nursing for humanitarian and altruistic reasons and are not afraid of hard work. We do fear is that harm will come to a patient because we are unable to give them the nursing care they need.

Nurses throughout the country tell NOVA that the Nursing FTEE have already been cut at their hospitals. Often when nursing positions are vacant because of recruitment difficulties, and the hospital budget requires that positions be cut, the empty nursing slots are sacrificed and the ceiling is reduced or frozen at a lower number. In this case the vacancy rate looks low and the budget appears to get balanced. NOVA's information confirms the VA survey of field facilities which reported budget reductions were cited for more than half the loss of registered nurses.

In the hospitals and clinics there are delays in scheduling patients for the medical follow-up and clinic appointments they need.and in many instances services have been severely curtailed or eliminated. For example at Brooklyn's Reyerson Street Outpatient Clinic all Rehabilitation Medicine has been eliminated, no proctoscopy is available due to the release of a General Surgeon, GU clinic has been curtailed to one day per week, ENT, Dermatology, and Podiatry Clinic have been reduced 25%. The patients who can no longer be served must go to the hospital for care where there is a 90 day wait for services. This wait may be disastrously long for the diabetic with a foot ulcer, the patient with an undiagnosed skin lesion, or the elderly male veteran with difficulty passing urine.

When a reduction of inpatient care is mandated or required because of staff reductions, shortages and bed closures it means that veterans in need of hospitalization wait for admission. When needed medical or psychiatric treatment is delayed, the patient may become more acutely ill, the hospital stay may be prolonged or the treatment and rehabilitation less effective due to additional problems or complications arising during the delay.

Support Staff

Nursing is not the only area where there have been staff cuts or there are shortages. VA nurses tell NOVA that there are shortages in other departments and nurses are required to fill in the gaps as respiratory therapists, blood drawers, ward secretaries and housekeepers. Systems intended to increase efficiency and accuracy such as unit-dose medication are compromised when pharmacy is short staffed and pours 2 or 3 days of medication on the unit dose cart. The burden to adjust falls on the shoulders of nurses. When nurses are used as the all-purpose disposable employee, patients are deprived of nursing care and nurses get used up.

Supplies, Medications and Equipment

When NOVA asked VA nurses if there were "difficulties in securing adequate supplies for patient care?" the answer we received from 82% of those who replied was "yes" there are difficulties.

A summary of their most common responses includes shortages in supplies needed for patient care such as, Kleenex tissues, 2x2 and 4x4 sterile gauze pads, urinals, adult diapers, 5cc syringes, foley catheters, IV needles, bedside urine bags, Swan Ganz catheters, colostomy bags, rectal thermometers, water pitchers, mouthwash, toothpaste and a basic hospital staple — SOAP. A national shortage of latex gloves last year was not unique to VA hospitals but it was an added stress as VA nurses attempted to institute universal infection control precautions.required as protection from AIDS.

IV solutions and common medications are also often ""Out of stock." The tight budget is frequently blamed when drugs are not available. "*Liquid haldol is too expensive*" we are told "*give it IM*" (Intra Muscular Injection) if the patient won't swallow the pill form. "Out of stock" items may seem like a simple inventory problem but there is an adverse affect on patients, nurses and physicians. For example, when a particular IV solution is not available nurses need to call or find the physician to re-write the doctors-orders for all the patients for whom that solution was ordered. This process absorbs the time of the physician and the nurse and deprives the veteran patient of their attention as well as the first choice in IV solution or medication.

In the name of budget constraints nurses report poor quality supplies are often substituted for those requested or recommended by nursing and medical staff. Nurses report this is particularly frustrating when this happens after the completion of a product comparison and evaluation period of 5 or 6 months, and nursing recommendations are ignored in favor of cost savings. Often clinical protocols are prepared based on the use of particular supplies and materials and nurses are unable to follow the appropriate procedures when substitutions have been made in the name of budget reductions. There is no real savings when a nurses time is wasted when the IV tubing is incompatible with the IV solution bottle and precious time is used to resolve the problem so the patient can receive the IV medication he needs.

Nurses from coast to coast reported that the purchase of equipment has been severely curtailed. Many report that no new or replacement equipment has been bought in over a year and that equipment dollars have been used to pay salaries. Basic equipment such as electric beds, infusion pumps, defibrillators, hydraulic lifts, wheel chairs, wheel chair cushions, and geriatric chairs are not available and the quality of patient care suffers.

When nurses in one hospital experience some of the shortages outlined above they are often convinced it is unique to their facility and caused by their: hospital director, chief nurse, chief of MAS, chief of supply, chief of personnel or chief of prosthetics. When NOVA hears similar reports throughout the country it seems clearer that nurses and departments everywhere are shifting and juggling and trying to survive in a system that is inadequately funded for the legislated mission.

Recruitment

The inadequate medical care budget has had an adverse impact on the ability of the VA to recruit adequate numbers of VA nurses. The nursing shortage that NOVA and other organizations have discussed before this committee in the past has moved beyond the urban centers on on each coast and is evident now throughout the nation. Many VA nurses report that recruitment of nursing staff is severely hampered because VA hospitals are not competitive with community hospitals in salaries for the entry level nurse or for the highly qualified experienced nurse. They confirm that the VA is also not competitive with local hospitals in fringe benefits, tuition reimbursement, staffing levels, weekends off and shift rotation. VA's inform us they have little or no money available to advertise and attract applicants.The problems are not identical in every hospital. Some report they have not been able to attract a new graduate to apply for a position in over two years and others report they can recruit only new graduates who work less than one year and then move on. It is not uncommon to take 90 to 120 days to fill vacant positions. The workload for the nurses who remain increases with each unfilled vacancy. This heavy workload affects recruitment because nurses frequently inquire about the nurse to patient ratio when they apply for work and decline employment when they hear the answer. This ratio not only indicates how hard they would have to work but primarily represents an indication of how committed the institution is to providing quality care.

NOVA has stated in the past that overworked nurses are poor recruiters for the VA system. Nurses are no longer a disposable commodity that can be disposed of cavalierly with the certain knowledge that there will be a great new supply to take their place. Retention of nurses already working needs to be our first concern.

Retention

It is difficult to know for certain why nurses decide to leave VA employment after many years of service. We contend that it is the cumulative effect of working short staffed, without the needed supplies and equipment and without competitive salaries and benefits that adds up and any one of these events can be the straw that breaks the camel's back. An example of one such straw is illustrated by the archaic overtime pay cap. It is not uncommon for a nurse to be asked to work a second shift in one day and earn less per hour for that second overtime shift than the original scheduled shift. All of this leads to an increased turnover rate. The high turnover of nursing staff creates an even higher workload when there are frequent new and inexperienced staff who must be monitored and this higher workload perpetuates high turnover.

The VA must no longer try to meet the budget targets by making unreasonable demands of nurses and breaking its covenant with sick and needy veterans. As the pressure has built to treat sicker patients in a more rapid time frame nurses have done their part. We have tried to prepare patients and families for earlier discharge. We have been a part of innovative non-institutional solutions such as Respite Programs, Adult Day Health Programs, Hospice and HBHC and utilization of community resources As we stated earlier NOVA is speaking today for the nurses who continue to stay and care for veteran patients in spite of all the difficulties described above. We are loyal and dedicated employees who pull together-in difficult times, who like taking pride in what we do and dislike seeing the VA attacked and criticized from without. We are resentful when non-VA nursing colleagues indicate they think the VA is a second class place to work or assume that if you can't work elsewhere you can always work at the VA. We have glimpses from time to time of how great the VA health care system can be and take pride in the system's accomplishments. We have a worthy mission and need the resources to fulfill that mission.

VA nurses are aware of the need for cost consciousness and restraint and continue to do our part. We desperately do need some relief from the constant. uncertainty the domination of budget considerations creates in the clinical area. From day to day our choices of patient treatment are influenced by the category the patient fits into.and what resources may be available when he is discharged. Nova urges you to reject the Administrations proposal to cut the medical care budget.and urge you to restore the 8,957 FTEE we need to care for our veteran patients. Additional funds will be needed to enable the VA to implement the necessary measures to recruit and most importantly retain the nurses who provide care.

Thank you Mr. Chairman for giving VA nurses the opportunity to share with you and the members of the committee the unique perspective that nurses bring from the bedside of veteran patients to these proceedings. Over thirty thousand nurses in the VA are placing their trust in you so that quality care will be provided to those who trust us.

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STATEMENT OF

VIETNAM VETERANS OF AMERICA

Presented By

THOMAS A. SHERWOOD
DIRECTOR OF HEALTH POLICY & PLANNING

and

PAUL S. EGAN
LEGISLATIVE DIRECTOR

before the

SENATE VETERANS AFFAIRS COMMITTEE

on

OVERSIGHT OF THE
DEPARTMENT OF VETERANS AFFAIRS'
HEALTH CARE SYSTEM

APRIL 6, 1989

Mr Chairman and members of the committee, the Vietnam Veterans of America, Inc. (VVA) appreciates the opportunity to present its views on the VA's health care system. We are all the more appreciative because our views, as expressed in this committee's health oversight hearing of September 9, 1988, again at the FY 1990 Budget hearing on March 6 of this year as well as at this hearing departs sharply from the chorus of views expressed almost uniformly by the other veterans service organizations. In this regard, we simply cannot see any way in which sufficient resources can be found to allow the Department of Veterans Affairs (DVA) health system to continue as it has in the past. The health system that has evolved over the years can no longer be afforded in its current form and it is playing a cruel joke on the nation's veterans who rely on this system to perpetuate the myth that it either is or can continue to be all things to all veterans.

Having said that, we most certainly agree that the health problems besetting the growing population of aging veterans cannot and should not be ignored. Apart from what might be seen or characterized as a contest between the health care needs of older and younger veterans, the VVA is attempting to open a dialogue within the veterans community that examines fiscally difficult questions in hopes of stimulating fiscally realistic policy decisions. In embarking on this course, we begin by asking; what is the most fundamental component of the

DVA health care mission? We have concluded that this underlying mission is generation - neutral and requires that the DVA's first obligation is to provide high quality and timely health care services to veterans with service related disabilities. It is hoped that the other organizations and those with a stake in the DVA's health apparatus will at least agree on this particular point.

It is also true that a large population of indigent veterans and veterans unable for a variety of reasons to afford their own health insurance cannot be ignored. Even after admitting this, there remains good reason under the fiscal circumstances to suggest that these issues, as important as they are, cannot be exclusively central to the debate over veterans health care as provided by an agency whose mission requires it to first consider the needs of those with the greatest claim on DVA resources, the service disabled.

To discuss this issue otherwise, in our view, raises some curious contradictions. Unfortunately, what this committee in conjunction with the veterans community are really debating is the merits and wisdom of a targeted form of national health insurance. The very same issues of health care for the aging, the indigent, the uninsured and the truly needy are what lie at the heart of the DVA health care debate as it has been shaped in recent years. What we should instead be discussing is the most appropriate health care role the DVA can play in providing quality services to only a narrow slice of deserving Americans. If the discussion must extend beyond this narrow focus, we should at least be prepared to admit that what we mean by "most deserving" holds the needs of the service disabled as a secondary matter.

Another curious facet of the debate on veterans health care is the history of most of the veterans organizations' claims that DVA health care constitutes an important part of the "social safety net" afforded to the neediest veterans. Against this history, the same groups have taken great offense to references holding DVA health care out as just another "welfare" program. Apart from the obvious question of how those organizations can have it both ways -- veterans health care both is and isn't a public assistance program targeted to the needy -- there is an additional lingering implication; non-veterans, aging, indigent and uninsured Americans should somehow be denied free health care while only veterans should be deserving of what in microcosm has actually become a targeted, though poorly functioning, national health insurance system. This is indeed curious given the long and consistent opposition of some veterans groups to national health insurance. The framework of the debate, as distorted and confused as it has become in recent years, makes it useful to review the facts on just who is using the DVA health system.

It has been stated that as high as 96 percent of the VA's current patient load consists of category "A" veterans. The latest figures we have been able to ascertain from the DVA, however, indicate that the actual percentage of category "A" veterans treated as inpatients is around 85 percent. Nevertheless, only 32.3 percent of the DVA's inpatients are service disabled. Of these only about 50 percent are being treated for service related disabilities.

In the "B" and "C" categories, veterans treated as inpatients are approximately 1.9 percent and 1.1 percent respectively with another 10 percent who are non-veterans or "others." The point here is that without correctly observing how few of the DVA's patients are either service disabled or being treated for service related disabilities, one could be incorrectly led to believe that all category "A" veterans are either service disabled or receiving treatment for disabilities incurred in service. They are not, but too many advocates in this debate are too silent on this fact. The question of "quality" at the DVA is also distorted and confused.

At this committee's hearing on March 6 it was collectively stated by the panel of Medical School Deans that without new infusions of resources, the hospital affiliations, whose research is said to sustain "quality" health care, will begin to pull away from the DVA leaving the agency bereft of its supposedly most dedicated care providers and holding dire consequences for veterans. The witness on the panel from the UCLA School of Medicine was particularly articulate in arguing that high quality will erode.

The entire question of "quality" in the debate on health care is one crying for definition. According to the practitioners carrying out the hands on care, "quality" is good if patients are properly attended to in a timely fashion. According to the patients, "quality" of care is good if proper attention is given by caring and competent practitioners with a favorable recovery from whatever caused the hospitalization. According to medical academics, "quality" seems to have less to do with actual patient care and satisfaction than with the availability of up-to-date equipment for use by students in an up-to-date environment with a near limitless supply of patients on whom students can rely for a wide variety of learning experiences.

The witness on the panel from the University of Maryland School of Medicine was particularly articulate at the Senate Veterans Affairs Committee's March 6 budget hearing in his remarks about the problems arising from the DVA's failure to sustain sufficient resources for medical equipment. It remains unclear whether resolution of the equipment problem would solve the quality of care problem as defined by the hands-on practitioners or the patients.

The witness on this panel from the University of Pennsylvania School of Medicine cited an example of deteriorating research conditions by pointing to a 25 percent reallocation of research personnel to primary psychiatric care. From the standpoint of "quality" health care, again as defined by the hands-on practitioner and the patient, it seems clear enough that a 25 percent shortage of primary psychiatric care personnel would assure substandard quality. It seems difficult to imagine what might be more important to the actual care given the patient than sufficient numbers of primary care personnel.

On balance, each of the witnesses on this particular panel spoke of "quality" care. Yet, how can the quality of a teaching environment be equated in real terms with the quality of care received by the patient? It is our hope that the policy choices this committee considers as a result of this oversight hearing will be clear about the definition of quality it uses when the policy choices embodied in authorizing legislation are made. Naturally, we hope the definition of "quality" used will reflect quality as it relates to the provision of hands-on care to the patient.

It is stated by others that without substantial infusions of added resources, the overall health system's ability to provide "quality" care will deteriorate to crisis proportions. If it is assumed that the current management configuration of the VA health system is as it should be and if it is further assumed that it is appropriate for the DVA health system to continue to be all things to all veterans, this particular point is absolutely correct. The fact is that fiscal limitations make it unaffordable to ignore either the DVA's management misconfiguration or its ongoing failure to provide the kind of quality that is satisfactory to the veteran consumer or his/her relatives. For the veterans we serve who must rely on the DVA for health care, quality has already deteriorated to crisis proportions. Overworked employees are unable to attend their charges properly and the result is poor morale. This situation makes quality, as measured by hands-on care, and patient satisfaction, a relative impossibility.

For those who doubt that quality in many facilities is substandard, the last sources of objective information on the issue are the views expressed by those with an agenda other than the quality of care as received and perceived by the veteran. Similarly the most reliable source of objective information will not come from those veterans in town for a weekend or weeklong veterans organization conference. By and large these veterans do not use the DVA health system. The best source of information will come from the hands-on health practitioners and the hospital patients.

Over the course of the last several years, the DVA's basic health delivery system has gone substantially unchanged and without challenge. The conventional wisdom has always preferred more money as a way of ameliorating deteriorating conditions over the more agonizing process of reevaluating what the DVA is doing, how much what it does costs and where it might more appropriately direct its attention. Today there is either no extra money or too little extra available to solve any of the most pressing health care problems in any meaningful way, absent serious reform of the system.

It is important to note that the VVA is uninterested in dismantling the VA health system. By contrast with some organizations making the case as best they can for the same old "more money" solution, we are looking at the configuration of the system with the interest of the veteran user first and foremost in mind. It is no longer clear that this is the primary motivation of other parties with a stake in DVA health care.

We are seriously worried that the DVA's health system will not survive without a new approach to maintaining its integrity. This irony is given added poignancy since few if any of the other service organizations have, for whatever reasons, been able to reach even a similar conclusion. Applying by analogy the same old "more money" medicine to the same old "all things to all veterans" health system illness must surely and inevitably exhaust the willingness of the Congress to continue adding resources without appreciable improvement in the patient. What will ~~we say~~ to the service disabled veteran in need of health care then?

If we assume for a moment that the Congress is willing to add new resources to DVA health care, the amount of these new resources will likely be marginal and spread out over the entire system so that each particular account is insufficiently augmented. A few examples may be useful under the circumstances to illustrate how minor budgetary add-ons will fail to improve quality or timeliness in health care without a fundamental reexamination of the system.

A bit more might be added to beef up personnel levels, but will this be enough to prevent an offsetting drain on health personnel by already scheduled new facility activations? A bit more might also be added to critical DVA health personnel salaries, but will this be enough to either restore the morale of already overworked health practitioners or prevent the growing attractiveness of the private sector to many? Once again this committee might be well advised to consider giving greater authority over personnel matters to the individual Medical Center Directors in the context of a general management decentralization strategy as suggested to this committee by the VVA last September, again on March 6 and again at this hearing.

A bit more might be added to prosthetic services, but will this be enough to significantly shorten the period a veteran must wait for a replacement prosthetic device? The waiting period here used to be two months. Today the waiting period can be as much as eight months. This situation is completely unacceptable since disabled veterans in need of prosthetic devices rely almost exclusively on the DVA for repairs, refittings and replacements.

A bit more might be added to replace dated medical equipment, but will this be enough to satisfy the teaching affiliations? It should be noted here that contrary to what might have seemed implied earlier in this statement, the VVA has not concluded that the teaching affiliations or the research conducted under their auspices is unnecessary to the DVA health system. The political support alone that is brought to bear in support of their programs offers a fairly apparent assurance that the DVA health system will keep its facilities sufficiently up-to-date with equipment and an appropriate configuration for the practice of modern medicine.

A bit more might also be added to the readjustment counseling service, but will this be enough to address the proportions of the PTSD problem as outlined by the just completed Research Triangle Institute study? As we suggested in our statement for the March 6 hearing before this committee, this problem should be clearly accorded priority status since PTSD is unquestionably related to military service and in most instances results from combat experience.

A bit more might also be added for activation of new outpatient clinics or replacement facilities, but will this be enough to stem increasing demand or to prevent the existence of phantom beds that are listed as operational but are not operating in actuality because of staff shortages? Once again, as suggested last September, on March 6 and again in this hearing, the statutory establishment of personnel ceilings and floors ignores realities at the Medical Center level. While it is true that we have seen OMB - inspired DVA decisions that play fast and loose with personnel in the health care arena, it must be remembered that these decisions have been made and imposed from above by an inappropriately centralized bureaucracy. This is why we have proposed a new, reversed management relationship between the Medical Centers and the Central Office in which the Central Office purchases the care provided by a Medical Center after careful Medical Center preparation of a budget proposal designed to meet the health needs of veterans locally. This new "fiduciary intermediary" relationship, if established by authorizing legislation and sheltered from OMB or heavy handed Central Office interference, would place decision - making where it belongs, at the hospital level.

The list goes on and on and if the history of incremental resource increases in the DVA health system over the last several years is any indication, the same seemingly unfocused and undirected approach may very well be repeated in fiscal year 1990. How can it be otherwise if new resources are again added without a system - wide reevaluation of mission, priorities and goals?

Moreover, the VVA wishes to be as clear as possible on the subject of resources. We see the need and we are absolutely prepared to ask for more resources in varied categories of the health care budget. But we are as yet unprepared to ask for more resources in the absence of a clear strategy designed to improve quality, most especially for those with the most legitimate claim on DVA dollars. These are the service disabled and those whose disabilities, though often not adjudicated as such, are clearly related to military service. This is most certainly the case, for example, with veterans afflicted with PTSD.

Throughout much of last year and continuing into this year, we have seen the DVA strained to its limits as it continues to face a severe funding shortfall. The evidence of this was perhaps best documented by the Disabled American Veterans in an August communication to each member of Congress detailing the health reductions in each state. A review of that list reveals that decisions were and continue to be made in which provision of health services are reduced without regard for the service disabled or non-service disabled status of the veterans affected. While this approach cannot be tolerated, it suggests an agency whose primary mission of treating the service disabled first is adrift. Without explicit direction through authorizing legislation this drift can be expected to continue. A continued policy of wholesale cuts in programs and beds with partial or total closings of health care facilities in DVA Medical Centers across the country no matter who is affected signals a crippling of the system and the need for action immediately.

Under the circumstances, the DVA health care system can no longer be expected to honor its contractual commitments for services in the private sector from year to year. It is losing the trust of the communities with which it deals by breaking its word, failing to pay its bills and failing to fulfill its obligations. This is an appalling state of affairs, especially regarding its contractual arrangements for the purchase of services for our PTSD-afflicted veterans. It is also a sad state of affairs with regard to the DVA's contractual arrangements with private providers of care in long term community facilities. All of this has an undermining affect on the government's credibility. It is unfortunate but it is the veteran, particularly the disabled veteran, who will pay for this loss of credibility.

The importance of credibility here must be emphasized. The DVA as well as the veterans community are keenly interested in securing an appropriate DVA share of the resources that will be made available for the war on drugs and for the treatment of AIDS in this country both this fiscal year and next. Unless and until the DVA can demonstrate that it can be a reliable partner in each of these efforts, the prospects for allocation to the DVA of appropriate resources to do its share will surely remain unclear in the minds of top policy-makers in both the OMB and the White House. So far, and judging by its across-the-board approach to reducing health care services, the DVA has failed to demonstrate its credibility even in the public sector.

The Secretary noted in the hearings of March 6, 1989 before the Senate Veterans Affairs Committee on the DVA budget that in terms of the dollars that the Honorable William Bennett, the new "Drug Tsar", will be spending in the area of drug abatement in this country he will require that the DVA simply get its fair share, but will the DVA get its fair share? We maintain that credibility will have much to do with the answer.

Congress for fiscal year 1990 may appropriate over 1.6 billion dollars for AIDS. The DVA cares for over nine percent of all AIDS victims in this country. Will the DVA get its fair share of those dollars -- somewhere around 160 million dollars? The $55.25 million obligated in the DVA budget is neither enough nor credible.

Mr Chairman, in concluding this statement we offer a variety of proposals in addition to those already outlined in this statement. Many of these have been presented to this committee before.

Our first concern is that quality health care be provided in a timely manner first and foremost to the veterans relying on the system. Currently, quality isn't just becoming poor, it already is substandard in many facilities. With no significant change in sight, we believe the service disabled deserve an opportunity to secure health care at a facility of their own choosing and at DVA expense, a facility operated either by the DVA or by the private sector but whose quality is satisfactory to the veteran. Short of this, we are condemning our service disabled to substandard health care in the name of the integrity of a system whose interests are failing to be responsive to the legitimate health needs of the very veterans the system was designed to serve.

ADDITIONAL RECOMMENDATIONS

1. After Congress appropriates the dollars for veteran care, the DVA should be using those dollars to purchase health care from the Medical Centers. The DVA needs to become a fiduciary intermediary at the national level and the Medical Centers should be given the opportunity to provide these services in exchange for a budget to operate the health care component based on the DRG/RAM system. This relationship between the DVA fiduciary intermediary and the Medical Center provider needs to be direct, above board, interactive, politically diminished, patient centered, and driven by the desire to provide a quality health care product. The DVA's Central Office (CO) role should be based on national clinical and administrative standards designed to provide the necessary guidelines and constructive support, both technical and professional, to the Medical Center in order to facilitate the guarantee of a good product.

2. Allow the Medical Center to initiate and design its own annual budget plan first. This should be done within the DRG/RAM rules, but the Medical Center Director should be required to justify his/her budget requests by tailoring Medical Center resource needs to the veterans it serves and relative to the specific needs of the community where it is located. This may mean the Medical Center will have to contract for some services and/or sell other services to sharing hospitals or health systems in that same community. The relationship between the Medical Center and the Central Office should be one in which the Medical Center sells services to Central Office and Central Office pays the Medical Center to provide services for veterans.

3. The DM&S Medical Regions must be eliminated. Other than draining resources from the Medical Center level, and serving as a launching pad for internal DVA political advancement and interference regarding resource allocation, these Regional Offices make few valuable contributions to the well-being of the Medical Center or its patients. The DM&S Regional Offices serve only to allow the DVA health care system to say it is decentralized when in fact it is not.

4. Both the DM&S personnel ceiling (and floor) should be eliminated altogether. Maintaining a national level of 194,000 plus health care FTEE without attending to the individual Medical Center work loads ignores reality at the local health

care delivery level. Such a national ceiling forces top down management to the eventual peril of the veteran in want of quality medical care. Instead, each Medical Center should be allowed to justify its own staffing needs based on what is required to get the job done. Among the many problems with centralized management which imposes a national ceiling is that the system cannot adjust to its actual staffing numbers as program needs, workload and bed occupancy rates change. This principle is acknowledged in the five hospital Management Efficiency Programs (MEPS) where there are no ceilings and the Director hires in accordance with program need and resource availability. This is a local management issue, not a national one.

5. The 90,000 bed ceiling should be eliminated altogether. Like the personnel ceiling, this too has been a failure. The recent House Veterans Affairs Committee review has clearly demonstrated that serious problems have developed in which there are phantom beds, beds counted but out of service due to staffing shortages, beds counted but out of service due to construction, beds sometimes counted and sometimes not but which are simply out of use and/or awaiting transition. It would appear that the DVA is unable to determine how many truly operating beds, from a planning perspective, are actually operational in the centralized system. This is an issue for local management, not national. The individual Medical Center, must be allowed to size itself based on health needs determined at the local level rather than by the Central Office.

6. The time has come for veteran customers, as users of the DVA health system, to be assured that Medical Center Directors have both the education and experience to manage their hospital systems. Traditionally, DVA Medical Center Directors have come from all disciplines such as personnel, engineering, medicine, administration, social services, supply, recreation, pharmacy, nursing, etc. We strongly recommend that regardless of what the discipline, the Medical Center Director have a graduate credential in health management systems. A few examples include Public Health Administration, Hospital Administration and Health Institutions Policy and Planning. Further, these health professionals should belong to a professional organization such as the American College of Health Care Executives or an accredited health care organization for which there is continuing education relative to current developments in the health care management and delivery fields. Even though having such credentials and belonging to such organizations offers no guarantee of competence, the exposure to the issues associated with operating health systems in the DVA can go a long way toward

assisting the DVA Medical Center Director in managing a complex health care system. Moreover, Medical Center Directors meeting these standards and with the full responsibility and authority to create and manage their own budgets and facilities should be an improvement.

7. Marketing and outreach strategies should be implemented as a means for forcing the Medical Centers to deliver a better product. The DVA almost hides from those it serves and therefore has no means of accountability for what it does. If the DVA is concerned that too many aging veterans in this country will suddenly flood the system, then it is appropriate to authorize the service disabled veteran to use a health provider of his or her choice at DVA's expense.

8. Create a governing board of veteran consumers at each Medical Center. The board functions should include but not be limited to:

- Holding the Medical Center Directors explicitly accountable for clinically based management of the Medical Center and for the provision of quality care in all areas.

- Participation in all major decisions in the management of the Medical Center, particularly if it relates to resources, affiliations, programs and key clinical and administrative appointments.

- Participation in policy implementation when the Central Office urges adjustments concerning health matters.

9. The entire mental health delivery system of the DVA should be reviewed in terms of program needs, availability, resource requirements and dedication, clinical and administrative organization and program priorities in view of budget constraints and competition with non-psychiatric programs. It has been well documented over the years that the DVA has not been successful in the provision of mental health care to those veterans it serves. Further, there are certain clinical confusions relative to mental health delivery that need to be addressed. As an example, the DVA treats alcoholism, drug addiction, and PTSD in many of its facilities as separate non-interactional clinical maladies. Treatment for each is provided under separate programs, separate budgets, separate staffs, separate ideological rationales and separate medical school affiliate interests. This approach is not only very costly but may not be in the best clinical interest of the veteran being treated in many instances. The veteran whose substance abuse problems are a component of his or her PTSD is a classic example. Under the circumstances, both the

substance abuse and PTSD problems must be treated together.

10. The relationships between the DVA and the teaching affiliations as well as between the DVA and the private sector should be carefully examined for the purpose of determining how veterans have been and can be affected both adversely and beneficially by change. Medical Center Directors have frequently noted the undue influence medical affiliations have had on their medical centers. The medical affiliations, by definition, have a set of priorities which relate to teaching, research and the interests of the medical school. It is well known that the first priority of the DVA medical center is patient care. Unfortunately, and sometimes to the detriment of the veteran patient, these two sets of priorities may conflict. In the areas of treatment programs, medical appointments and the allocation of funds, the medical schools can exert too much influence over the Medical Center Directors. This influence is usually on the Medical Center directly, but also through the DVA medical regions and at the Central Office level via the office of academic affairs.

11. Authorize service disabled veterans to obtain medical services from providers of choice at DVA expense. Veterans who are disabled as a result of military service are the most deserving of DVA resources. Unfortunately, the DVA's attention to so many other competing demands on the health care system has detracted significantly from the service disabled veteran's ability to receive health care on a priority basis. Additionally, the quality of health care in many DVA facilities has deteriorated. In order to provide the best possible and most timely care to the satisfaction of the disabled veteran, a provider of choice program is needed to assure that the most deserving of the nation's veterans are treated properly.

12. Authorize a comprehensive program for addressing the high incidence of PTSD among veterans, particularly combat veterans. The DVA's own Research Triangle Institute study (RTI) and the American Legion/Columbia University study have demonstrated that PTSD in veterans is far more prevalent than previously expected. The RTI study found that 15.2 percent of all male Vietnam theater veterans currently have PTSD. This is estimated to be 479,000 veterans. Another 27.9 percent of hispanic male Vietnam theater veterans, 47,000, have PTSD. Of white male Vietnam theater veteran, 13.7 percent or 359,000 veterans have PTSD. Among black male Vietnam theater veterans, 20.6 percent or 72,000 have PTSD. Of those veteran with or having had PTSD, only 10 percent have ever been treated by the DVA. This situation is clearly deserving of serious attention and resources and is justified by the DVA's

primary mission of caring for veterans with service related disabilities.

The VVA recommends a significant expansion of the Vet Center program and a requirement that the DVA open an inpatient PTSD unit in each of the 27 medical Districts. To develop and attract enough qualified personnel to operate these inpatient units, it is recommended that a scholarship program be developed and implemented for purposes of exchanging educational assistance (for graduate programs in training relevant to PTSD treatment) for a DVA service obligation by each program participant. Such a scholarship program would be modeled after the VA's nurse scholarship program. In addition to this a research program should be established with at least three inpatient PTSD units. Research conducted in these pilot units would be directed toward ascertaining the most effective PTSD treatment modalities. As the DVA's general expansion of inpatient PTSD units proceeds, the findings of the research pilot units could be applied. Additionally, expanded resources for contract readjustment counseling in areas lacking "Vet Centers" should be provided and protected from reduction or diversion to other programs by the VA's Central Office management. Moreover, outreach must be taken seriously in the program. Finally, and in connection with outreach, the DVA should undertake to assist penal institutions in identifying and properly treating incarcerated veterans with PTSD.

ALAN CRANSTON, CALIFORNIA, CHAIRMAN

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United States Senate
COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, DC 20510-6375

April 12, 1989

Mr. Jerry Cox
Service Officer
Disabled American Veterans
VAROIC P.O. Box 13399
Wassahickon and Manheim Streets
Philadelphia, Pennsylvania 19101

Dear Mr. Cox,

Thank you for your testimony at the Committee's April 6 oversight hearing on VA health care. As I indicated at that hearing, enclosed are a number of follow-up questions as to which I would appreciate your views for inclusion in the hearing record.

Please respond to these questions by April 24.

Thank you for your cooperation.

With best wishes,

Sincerely,

Alan Cranston

Alan Cranston
Chairman

Enclosure

Written Questions from Senator Alan Cranston
in follow-up to April 6, 1989, Health Care Oversight Hearing

1. I would appreciate your providing to me separately and confidentially the names, addresses, and claims numbers of the veterans whose cases you described and the names of medical centers you refered to in your testimony so that I can look into these matters further. (If I were to decide to contact VA about a veteran's case by name, I would first obtain the veteran's written permission to do so.)

2. Have you seen a specific impact of the funding shortfall on VA's ability to provide prosthetic devices and, if so, what has happened to the veterans affected?

3. I am concerned about the extent to which there is an understanding in the larger community about the current VA funding crisis and the impact of this situation. Do you believe that those in your local community -- veterans and non-veterans alike -- who do not rely on VA for care understand what is happening with VA funding and what the likely impact will be in terms of demand for care from other community health-care facilities if VA facilities are unable to meet the demand for care from eligible veterans?

4. On page 3 of your statement, you discuss a PTSD ward that has only 30 of 51 beds open at this time and you state that "the waiting list existed due to staffing shortages." Is the staffing shortage related to the budget shortfall or is it related to some other recruitment and retention problem at that medical center?

Disabled American Veterans
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April 19, 1989

The Honorable Alan Cranston
Chairman
United States Senate
Committee on Veterans' Affairs
Washington, DC 20510-6375

Dear Senator Cranston:

This correspondence is in reference to your letter of April 16, 1989, requesting additional information pertaining to my testimony at the Committee's April 6 oversight hearing on VA health care.

In response to question one (1):

Page 2, Paragraph 2 - Lebanon VA Medical Center
Lebanon, PA

Page 3, Paragraph 2 - Coatesville VA Medical Center
Coatesville, PA 19320

Page 3, Paragraph 3 - Philadelphia VA Medical Center
Philadelphia, PA

Page 5, Paragraph 1 - Pittsburgh VA Medical Center
University Drive C
Pittsburgh, PA

Page 7, Paragraph 2 - Wilkes-Barre VA Medical Center
Wilkes-Barre, PA

Page 9, Paragraph 1 - VA Regional Office
Phila., PA

VA Regional Office
Pittsburgh, PA

Senator Alan Cranston, Chairman
Page 2
April 19, 1989

In response to question two (2): I have not received any specific complaints from veterans with reference to not receiving prosthetic devices when needed. I have been told, however, that there is shortfall of funds for the prosthetic service and that prosthetic chiefs must be frugal in the use of funds that are available.

In response to question three (3): I believe that the majority of individuals in this community have no idea as to the importance of VA health care for this Nation's veterans. The cutting of the VA health care budget is not front page news or a lead off story for the evening news. Most people, therefore, are not aware of the crisis of the Health System.

In response to question four (4): The Coatesville VA Medical Center is a psychiatric hospital. According to the Assistant Director, only 30 of the 51 beds are in use. This is due to staffing shortages.

Sincerely,

JERRY D. COX, SUPERVISOR
National Service Officer

JDC:tw

ALAN CRANSTON, CALIFORNIA, CHAIRMAN

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DENNIS DeCONCINI, ARIZONA
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JONATHAN R. STEINBERG, CHIEF COUNSEL/STAFF DIRECTOR
ALAN C. PTAK, MINORITY CHIEF COUNSEL/STAFF DIRECTOR

United States Senate
COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, DC 20510-6375

April 12, 1989

Mr. Larry Dawson
Service Officer
Disabled American Veterans
VA Regional Office, Suite 409
3225 North Central Avenue
Phoenix, Arizona 85012

Dear Mr. Dawson,

Thank you for your testimony at the Committee's April 6 oversight hearing on VA health care. As I indicated at that hearing, enclosed are a number of follow-up questions as to which I would appreciate your views for inclusion in the hearing record.

Please respond to these questions by April 24.

Thank you for your cooperation.

With best wishes,

Sincerely,

Alan Cranston

Alan Cranston
Chairman

Enclosure

Written Questions from Senator Alan Cranston in follow-up to April 6, 1989, Health Care Oversight Hearing

1. I would appreciate your providing to me separately and confidentially the names, addresses, and claims numbers of the veterans whose cases you described and the names of medical centers you refered to in your testimony so that I can look into these matters further. (If I were to decide to contact VA about a veteran's case by name, I would first obtain the veteran's written permission to do so.)

2. Have you seen a specific impact of the funding shortfall on VA's ability to provide prosthetic devices and, if so, what has happened to the veterans affected?

3. I am concerned about the extent to which there is an understanding in the larger community about the current VA funding crisis and the impact of this situation. Do you believe that those in your local community -- veterans and non-veterans alike -- who do not rely on VA for care understand what is happening with VA funding and what the likely impact will be in terms of demand for care from other community health-care facilities if VA facilities are unable to meet the demand for care from eligible veterans?

4. I have some questions about points you raised in your written testimony:

A. First, you noted that two wards are closed at the Tucson VAMC; how many beds are involved?

B. You stated that there is a large unmet need for maintenance and replacement of equipment at the Tucson VAMC. Do you have a dollar figure that is needed to take care of that need?

C. You stated that, in your view, the Phoenix VAMC should be treating 250,000 outpatients annually. How did you arrive at that number?

D. Also with reference to the Phoenix VAMC, you noted that one ward is closed due to inability to staff it adequately. I have four questions:

i) What kind of a ward is it?

ii) How many beds are involved?

iii) Is the inability to staff it due to the funding shortage?

iv) If you know, how many staff would be needed to reopen it?

E. With reference to the Prescott VAMC, you indicated that a ward closed for renovation remains closed due to budget restraints. Again, what kind of ward is it, how many beds are involved, and, if you know, how many staff would be needed to reopen it?

F. With further reference to the Prescott VAMC, you noted that a 60-bed nursing home -- expandable to 120 beds -- will be completed next month. You then stated that "the facility has no equipment nor funds for staffing to make this facility available for care of those so deserving." Were you suggesting that the home would not open at all even with only 60 beds?

Disabled American Veterans
National Service Office
VA Regional Office • Suite 409 • 3225 North Central Avenue • Phoenix, AZ 85012
(602) 241-2455

May 1, 1989

Senator Alan Cranston, Chairman
Committee on Veterans' Affairs
United States Senate
Washington, D.C. 20510-63

Dear Senator Cranston:

In response to your request of April 12, 1989 concerning clarification on questions asked at the hearing held on April 6, 1989, I would like to respond by outlining my response in the same order as your questions.

1. In my testimony, I did not discuss individual claimants. Therefore, I can not respond with names.

2. I can not specifically respond to what has created the difficulty in veterans obtaining prosthetic devices. We have incurred a difficulty level for veterans with eligibility for prosthetics to obtain them on their original request. A lot of cases will have to appeal to the Rehabilitation Committee at the hospital and/or undergo a long delay in the response time. On those cases that do come to our attention where wheelchairs, crutches, or cains are needed, we have been able to obtain this equipment from our own individual Chapters who maintain a supply of some prosthetic equipment that has been left to them by other veterans.

3. In my own opinion, I firmly believe that the bulk of people in the community where we serve have a very distinct lack of understanding with the current veterans affairs situation. The majority of the people who are not obtaining care at the VA Medical Center, at the current time, feel it will always be there to provide assistance when the need arises.

4a. The two wards closed at the Tucson VAMC are Ward 1 South, with 29 bed capacity and Ward 5 with a 46 bed capacity, 29 of which are for chronic psychiatric care and 17 for acute alcohol abuse care.

4b. I obtained clarification of the maintenance and replacement of equipment that I had previously received and it was for the generic need rather than specifically for the VA Medical Center. The statement was made more in line with the discontent with the formulary system utilized already by the Department of Medicine and Surgery.

PAGE TWO

4c. Our figure of 250,000 outpatients that should be treated at the Phoenix VA Medical Center was based on the national average of 10% of the veterans being treated in a catchment area.

4d.

i) The ward closed at the Phoenix VA Medical Center is a surgical ward.

ii) There are 33 beds involved.

iii) Today funding is the basis for the inability to reopen the ward. Originally, the ward was closed as the VA could not obtain adequate staffing from the community.

iv) To reopen the ward today, it would take 16 people to staff the ward, consisting primarily of RN's and LPN's.

4e. The ward that is closed at the Prescott VA Medical Center, upon completion of renovation, was to be a 30 bed chronic psychiatric ward. Although it was closed for renovation purposes, the renovation has not yet been completed due to budget restraints.

It would require 22 positions for staffing purposes. The funds are not available in the 1989 budget year. It is our understanding from the Prescott facility that non-recurring funds of $50,000.00 are needed for renovation and an additional $39,000.00 for furniture and equipment. The facilities needs for staffing and operation costs for the first year would be $794,000.00.

4f. I had indicated the nursing home at the Prescott VA Hospital was a 60 bed nursing home with the capability of expansion to 120 beds. It was to be completed by May 19, 1989. Previous approval had been for the nursing home to open at a 60 bed level. It appears that completion of construction will be accomplished on the aforementioned date. The hospital does not currently have the funds for either equipment nor staffing of this nursing home in the 1989 budget year. It is our understanding that if the Supplemental Appropriations Bill is approved that the funds to furnish and equip the nursing home will be allowed. For staffing purposes, the hospital will have to await the 1990 budget before they will know for sure if funds have been made available.

If I can be of assistance in obtaining any additional information or answer any further questions, please call upon me to do so.

Sincerely,

Larry J Dawson

Larry J. Dawson
Supervising
National Service Officer
LJD/gj

QUESTION FROM CHAIRMAN CRANSTON TO GARY DeGASTA AND THE RESPONSE

Regarding your request for a written response to the implications of the FY 89 funding shortfall on the , I offer the following:

Upon my arrival as Director of White River Junction VA Medical and Regional Office Center in November, 1987, Vermont's only VA Medical Center was facing a $1.7 million recurring shortfall in our FY 88 budget. I immediately dealt with this severe deficit through initiating a series of HORIZONTAL reductions, resource reallocations, the implementation of a strict hiring freeze (including permanent ceiling reductions of 31.8 FTEE). By the end of the Fiscal Year, we achieved a reduction of 75 personnel, redirecting nearly every Non-Recurring (NR) dollar of our equipment and Non-Recurring Maintenance (NRM) accounts and diverting Medical District Initiated Program Planning (MEDIPP) monies (which were to be used for new programs) to cover our recurring deficit. In spite of these actions, in order to complete FY 88 without becoming antideficient, it was still necessary for me to secure considerable (non-recurring all other) funds from the Northeaster Regional Director as well as obtain his authority to use our non-VA workload NR accounts (Fee Medical, Fee Dental, Contract Hospitalization, etc.) to support the recurring shortfall.

Our FY 89 budget plan, which evidenced only a very small actual increase in our recurring funding base, was submitted earlier this Fiscal Year in conformity with Regional guidelines and VACO directives. However, since we had already exploited our Center's ability to absorb horizontal cuts during the previous Fiscal Year, the only way to achieve our mandated $18,764,196) FY 89 personal services target (given to White River Junction in the budget plan) was to make vertical cuts and to create a significant shortfall in our "all other" accounts. In sum, White River Junction's Target Allowance (TA) reflected a $1.8 million recurring deficit over our operating needs -- $600 thousand in personal services and $1.2 million in all other.

The Management philosophy we adopted to cope with this untenable financial situation was to protect our essential "core" acute inpatient (medicine, surgery and psychiatry bed sections) and critical outpatient activities (short stay unit, patient lodge and primary care treatment orientation) and eliminate, through vertical program reductions, the programs necessary to keep the Center within its assigned budget. In sum, to retain quality in the programs we determined to be essential to our veteran-patients (because of our small size), the only other programs available to sacrifice were our 30 bed Nursing Home Care Unit (NHCU), our Hospital Based Home Care (HBHC) program and our 16 bed Alcohol Rehabilitation Program (ARP). I subsequently withdrew from service ceilings 40.1 FTEE. Unfortunately, even these actions did not yield enough dollars to cover the deficit. Therefore, upon the recommendation of the Pharmacy and Therapeutic (P&TP Committee and the Clinical Executive Board (CEB), I approved the elimination of Over the Counter (OTC) drugs from our Formulary for all three categories of veterans (A,B,and C). We concurrently stopped issuing medical and ostomy supplies as OTC drugs. (Recent national policy clarification by Central Office of over the counter drugs has provided an opportunity for us to resume the provision of ostomy and other essential medical supplies.) The hiring lag instituted in FY 88 has also continued into FY 89. (Today, we have eighty-nine [89] fewer employees on duty at our Center than we had when I arrived.) Also, since we exceeded our prescribed percentages (of 8.3% for outpatients and 1.5% for inpatients) for Category B and C workload, I ordered a drastic curtailment in the care provided to our Category B and C veterans. We sent out letters to over 1500 veterans informing them they may no longer be eligible. In the end we found nearly 1,000 veterans who did not meet the eligibility criteria. Even with these additional draconian actions, there remained some doubt about whether or not we would be able to achieve sufficient dollar reductions to keep the Medical Center from becoming antideficient by the end of the Fiscal Year.

Severe pressures brought by Vermont's U.S. Congressional Delegation, led by Senator Patrick Leahy, supplemented by support from our veterans organizations, citizens of the bi-state area (Vermont and New Hampshire) and the Governor of the State and the State Legislature, directed that I reopen two of the three programs which were closed because of resource constraints -- Nursing Home Care Unit (NHCU 30 beds) and HBHC. To date, our Center has received from VA Central Office, a 50% "installment" ($439,000) of the $878,000 we required to reopen and keep the programs operational. Should the remaining funds not be forthcoming for this year and/or not be annualized for subsequent years, it may be necessary to once again take action to reduce or eliminate programs in order to retain quality care in the programs we can afford to retain.

The following actions have also been undertaken:

- reduced discretionary inpatient workload
- reduced outpatient workload (concentrating on discretionary workload)
- developed and implemented an "administrative screening" process (in conjunction with clinical evaluation process) to restrict veteran-patient access "at the front door"
- restrict orthopedic joint replacements to one per week (or less)

3.

Should financial relief not be forthcoming, the following additional actions have been contemplated and may have to be undertaken:

* discharge from our rolls all remaining discretionary workload (Category B and C - those currently within the 8.3% corridor for outpatients and 1.5% corridor for inpatients) utilizing existing VA policies (12 month review of patients on ambulatory care programs) and other internal review mechanisms, and where necessary, begin to limit access to lower priority Category A veterans.

* wherever feasible, recall Fee Basis cards

* curtail provision of select services (radiation therapy and orthopedic joint surgery) we currently provide to our sister VAMC's in NH and MA

* drastically reduce visiting nurse (VNA) followup activities to patients both inside and outside our Primary Service Area (PSA)

The following are some of the "anticipated impacts" on our Center, our affiliates (Dartmouth Medical School, Dartmouth Hitchcock Medical Center, etc.) and the political, social and geographical communities in which we operate should our resources not keep pace with our needs:

* Continued deterioration of Center equipment and facilities. We are in the second year of virtually purchasing no medical equipment.

* A serious impact on our affiliated Medical School. (We provide fully 1/3 of the teaching of students for the Dartmouth Medical School, Hanover, NH. Workload reductions will require reduction in the number of students taught.) Any precipitous withdrawal of resources will not allow the medical school time to make other arrangements.

* Not only will our $1 million VA funded research program suffer but the affiliated Medical School's research programs will be impacted as will our Center's potential to attract and recruit quality medical researchers.

* Patient outcomes will be adversely affected through the absence of continuity of care and viable community alternatives of care -- patients in need of joint replacement are having to wait for months for an opening due to out limiting joint replacements to 1 per week due to constraints.

* The elimination of a variety of inpatient programs (NHCU, ARP) may cause us to increase our hospital length of stay -- chronic patients will occupy our acute beds because we cannot place them, thereby

reducing hospital access to acutely ill patients.

* The demand on already scarce skilled non-VA community nursing beds in upper New England will become more intense.

* Complaints to Members of Congress can be expected to continue or increase as a result of a decrease in service availability and reduced access to VA healthcare and a belief that there has been a breach in a commitment to care for veterans by their Government. (Senators Jeffords and Leahy and Congressman Smith have reported receiving thousands of letters from their constituents.)

* Family support systems will decrease in effectiveness due to having to travel greater distances for health care and the inaccessibility of care.

* Public relations and community support of veterans programs will be dramatically affected due to a perceived breach of contract.

* Other federal programs (Medicare/Medicaid) will be increased in their workload and cost due to decreases in VA healthcare services.

* Morale of VA Center staff, already at an all time low, will further diminish as our program reductions effect the overall breadth and scope of services we provide.

* Professional staff will be lost with little hope of replacement because of the adverse effect on our reputation (this has already happened with the nursing personnel we lost when we closed our programs in January -- we cannot get them back!). (It took us nearly 2 years to recruit a vascular and a general surgeon and nearly 2 years to recruit a radiologist because our current salary structure for physicians is non-competitive.)

* Vermont and New Hampshire, having one of the lowest unemployment rates in the Nation (1½ to 2%), creates an environment where employees have little difficulty in soliciting other employment opportunities. This affects both recruitment and retention.

* Center staff has not yet fully recovered from severe horizontal reductions accomplished during FY 88 and face additional uncertainties and fear of additional budget and program reductions.

* The "critical mass" of certain Center programs will be lost -- a small facility such as White River Junction, has little depth.

* The White River Junction VA Center has a proud and distinguished 50

year history of rendering quality treatment to all veterans who seek care. Restricting access, while necessary, will not be readily accepted by our veteran-beneficiaries and their families and friends.

- * Significant decrease in category C may reduce reimbursable insurance billings and collections due to a loss of the discretionary workload. (recent policy changes in the VHS&RA's policy mitigates this some what.)
- * Sharing agreements will suffer. Certain patients seen under sharing agreements are discretionary workload. (Another recent interpreta tion of VHS&RA policy in this regard now permits VAMC's to count certain sharing agreements as non-discretionary workload and also mitigates this somewhat.)
- * Some counties in our bi-state Primary Service Area are underserved due to a lack of adequate community physicians and ambulatory care services.

On the macro level, when the Congress addresses the VA budget and its national policy decisions regarding veterans health care, it must no lose sight of the significant impact budgetary and policy actions have on the healthcare of individual veteran-beneficiaries. In Vermont, the implementation of the National budgetary policies has forced me to deny access to VA health care to scores of Vermont and New Hampshire veterans. Many of these veterans are not likely to obtain a full range of healthcare outside the VA system (because of financial, logistical, and/or other legitimate reasons).

Medical and Regional
Office Center
Togus ME 04330

Veterans
Administration

April 12, 1989

In Reply Refer To: 402/001B

Honorable Alan Cranston
Chairman, Committee of
Veterans Affairs
United States Senate
Washington, D. C. 20510

Dear Mr. Chairman:

I wish to thank you for the opportunity to participate in the hearings before the Senate Veterans Affairs Committee last week. I am hopeful that the hearings will result in a positive outcome.

You requested that in follow up to my testimony, I provide you with information regarding our FY '89 budget plan for the hospital operations at Togus; specifically asking the question, "What steps would Togus have to take if no additional supplemental funds are forthcoming?". Our response to that is as follows:

Although our employment level has been reduced significantly from fiscal year '88, we are still experiencing a salary deficit of approximately $900,000. The following actions are planned to cover this deficit:

1. Four hundred thousand dollars will be shifted from the community nursing home program to salary dollars;

2. one non-recurring maintenance project will be deferred, shifting $412,000 to salary dollars; and,

3. approximately one-half of our equipment dollars - $100,000 - will be shifted to salary dollars.

If Togus receives any supplemental funding this fiscal year, we will utilize the funds to support our salary deficit and proceed with funding the above items as originally intended to the maximum extent possible.

If you require any additional information, feel free to contact me at (207) 623-5716. Thank you for your support.

Sincerely yours,

THOMAS A. HOLTHAUS
Center Director

ALAN CRANSTON, CALIFORNIA, CHAIRMAN

SPARK M. MATSUNAGA, HAWAII
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ALAN C. PTAK, MINORITY CHIEF COUNSEL/STAFF DIRECTOR

United States Senate
COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, DC 20510-6375

April 12, 1989

Mr. Robert Newsome
Service Officer
Veterans of Foreign Wars, Department of Virginia
101 South Whiting Street
Suite 108
Alexandria, Virginia 22304

Dear Mr. Newsome,

Thank you for your testimony at the Committee's April 6 oversight hearing on VA health care. As I indicated at that hearing, enclosed are a number of follow-up questions as to which I would appreciate your views for inclusion in the hearing record.

Please respond to these questions by April 24.

Thank you for your cooperation.

With best wishes,

Sincerely,

Alan Cranston

Alan Cranston
Chairman

Enclosure

Written Questions from Senator Alan Cranston
in follow-up to April 6, 1989, Health Care Oversight Hearing

1. I would appreciate your providing to me separately and confidentially the names, addresses, and claims numbers of the veterans whose cases you described and the names of medical centers you refered to in your testimony so that I can look into these matters further. (If I were to decide to contact VA about a veteran's case by name, I would first obtain the veteran's written permission to do so.)

2. Have you seen a specific impact of the funding shortfall on VA's ability to provide prosthetic devices and, if so, what has happened to the veterans affected?

3. I am concerned about the extent to which there is an understanding in the larger community about the current VA funding crisis and the impact of this situation. Do you believe that those in your local community -- veterans and non-veterans alike -- who do not rely on VA for care understand what is happening with VA funding and what the likely impact will be in terms of demand for care from other community health-care facilities -- very likely at public expense -- if VA facilities are unable to meet the demand for care from eligible veterans?

4. On page 8 of the combined VFW statement, it is noted that "Category 'B' and 'C' veterans are being turned away from all the VAMCs in the Commonwealth of Virginia" and that the same was true at four other VAMCs in this general region -- the Martinsburg, Mountain Home, Durham, and Washington, D.C., VAMCs. Is this the case for both inpatient and outpatient care at each VAMC?

VETERANS OF FOREIGN WARS
OF THE UNITED STATES
FOUNDED 1899

AN ASSOCIATION OF MEN
WHO HAVE FOUGHT AMERICA'S
FOREIGN WARS ON LAND, SEA
AND IN AIR.

STATE HEADQUARTERS
ROUTE 11, SOUTH
P. O. BOX 2067, PHONE 703-886-8112
STAUNTON, VIRGINIA 24401

STATE OF VIRGINIA
OFFICE OF:

Robert A. Newsome

April 14,1989

Senator Alan Cranston
United States Senate
Committee on Veterans' Affairs
Washington, DC 20510-6375

Dear Senator Cranston:

Thank you for your letter dated April 12, 1989 alluding to the testimony given before your committee.

You will find enclosed a list of veterans; medical centers; addresses and telephone numbers that you asked for.

Yes, I have seen an impact on the shortness of funds for prosthetic devices. Enclosed you will find an application for adaptable equipment dated July 21, 1988. Also you will find a letter from the VA dated December 16, 1988, advising that they are processing claim. You will notice the time-frame of the application. The last time I spoke with he had not received his equipment. This is a standard practice of the VA concerning prosthetic devices.

The answer to your question number 3. The impact on the veterans in the community that no longer get medical treatment at VA facilities places a large impact on the local facilities taking into consideration that the veteran has no health care insurance. As you know, local health care facilities will not admit or see an individual unless he has some type of insurance.

The answer to your question number 4. Some As, Bs and Cs are being turned away from all of the medical facilities that you listed because of the shortfall in their budgets. In most of these medical facilities they have closed wings/closed beds because they do not have the funds to maintain the facilities properly as required by law.

Sincerely,

Robert A. Newsome

Robert A. Newsome
Service Officer

Enclosure

Medical Center

1601 Perdido Street
New Orleans LA 70146

Veterans Administration

April 13, 1989

In Reply Refer To: 629/11

Honorable Alan Cranston
Chairman
Committee of Veterans Affairs
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

Enclosed is the reply to the question asked at the Senate Hearings held in Washington on April 6, 1989. Also enclosed is a copy of the pertinent portions of a memorandum from the Chief of the Orthopaedic Section to the Chief of Staff at the New Orleans VA Medical Center.

I appreciate the privilege of testifying before the Committee to provide information which may be helpful in obtaining funding which will enable us to maintain the quality of services rendered to veterans.

Sincerely,

SAM A. THREEFOOT, M.D.
Chief of Staff

Enclosure

"America is #1—Thanks to our Veterans"

RESPONSE FOR VETERANS AFFAIRS COMMITTEE HEARING APRIL 6, 1989

QUESTION: What steps do you have to take if no additional funds are provided this year?

ANSWER: From VA Medical Center, New Orleans, LA:

A. Reduce elective surgeries

For non-emergent or non life-threatening procedures, only a budgeted number of cases will be allowed.

B. Restrict new admissions for Category B and C patients

Category B and C patients will be accepted only in emergent or life-threatening situations, both outpatient and inpatient.

C. Establish stricter protocols for high-cost/high-tech procedures

Less expensive alternatives will be explored prior to approving these procedures, especially protocols provided by contract, i.e. MRI's, Radiation Therapy, etc.

D. Review prescription drugs on formulary

The use of high-cost drugs will be screened for less expensive therapies. New medications will not be added to the formulary unless a real cost savings is identified.

E. Reduce Employment

We will be unable to fill vacancies due to FTEE ceilings and dollars available to pay salaries.

F. Request RD approval to convert non VA workload monies to cover in-house requirements

Stricter requirements for eligibility in these programs will reduce the requirements for these non-recurring funds; therefore, allowing us to convert these resources for in-house use.

G. Restrict admission to clinic

Clinics with excessive waiting times for appointments will not accept new admissions until the rolls are reduced to acceptable levels.

H. Review clinic appointments

Review scheduled outpatient visits to determine if delaying appointments would be compatible with treatment plans, in order to reduce the total number of visits.

I. Screen service connected veterans

As a last resort, become more rigid in treating service connected veterans for only their service connected condition.

Veterans Administration

Memorandum

Date April 3, 1989

From Chief, Orthopaedic Section (112)

Subj Reasons for Waiting List

To Chief of Staff (11)
THRU: Acting Chief, Surgical Service (112)

1. There are 21 patients on the waiting list for total joint replacements. These patients have been followed in the Outpatient Clinic during the past several months. Due to lack of funding, which limits the number of prostheses we can purchase per quarter, their surgery cannot be performed in a timely fashion. Most of these patients have advanced arthritis that has destroyed the functional capacity of the joint involved causing severe pain and decreased quality of life.

2. Priority is determined by the severity of the disease process. Those patients that have advanced disease and that are more affected functionally and in greater pain receive a higher priority than those that do not.

3. The main reason that these patients are going to have the surgery is to relieve the pain in their joints, improve the functional capacity and improve their quality of life. Many can only ambulate with the assistance of a cane or crutches and some are wheelchair bound because of pain and deformity and the crippling arthritis in the joint. The total joint replacement should alleviate their pain and improve their ambulatory status and their quality of life should also improve as well.

4. If surgery is further postponed, it is very possible and very predictable in some patients that they will continue to deteriorate until they are wheelchair bound or bedridden because of pain and crippling arthritis. The long term results of this are as follows: the chronic pain, depression, ambulation is prevented because of pain and crippling deformity in the joints which can lead to bedridden state. In the chronic bedridden state, the patient is very susceptible to pneumonia and decubiti which can be life threatening and in many times are the cause of death in such patients.

ALAN CRANSTON, CALIFORNIA, CHAIRMAN

SPARK M. MATSUNAGA, HAWAII
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ALAN C. PTAK, MINORITY CHIEF COUNSEL/STAFF DIRECTOR

United States Senate
COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, DC 20510-6375

April 12, 1989

Mr. Richard Woodworth
Service Officer
Paralyzed Veterans of America
Room 2D100
1030 Jefferson Avenue
Memphis, Tennessee 38104

Dear Richard,

Thank you for your testimony at the Committee's April 6 oversight hearing on VA health care. Your description of specific cases was most compelling, and I want you to know that I asked VA Chief Medical Director Dr. John Gronvall to look into and provide the Committee with reports on the cases of Billy Craft and Mike Williams. With specific reference to the Williams case, I also asked Dr. Gronvall to look into the overall question of the safety of the catheters being used.

As I indicated at that hearing, enclosed are a number of follow-up questions as to which I would appreciate your views for inclusion in the hearing record. Please respond to these questions by April 24.

Thank you for your cooperation.

With best wishes,

Sincerely,

Alan Cranston

Alan Cranston
Chairman

cc: Mr. Jack R. Powell

Enclosure

Written Questions from Senator Alan Cranston
in follow-up to April 6, 1989, Health Care Oversight Hearing

1. I would appreciate your providing to me separately and confidentially the names, addresses, and claims numbers of the veterans whose cases you described and the names of medical centers you refered to in your testimony so that I can look into these matters further. (If I were to decide to contact VA about a veteran's case by name, I would first obtain the veteran's written permission to do so.)

2. Have you seen a specific impact of the funding shortfall on VA's ability to provide prosthetic devices and, if so, what has happened to the veterans affected?

3. I am concerned about the extent to which there is an understanding in the larger community about the current VA funding crisis and the impact of this situation. Do you believe that those in your local community -- veterans and non-veterans alike -- who do not rely on VA for care understand what is happening with VA funding and what the likely impact will be in terms of demand for care from other community health-care facilities if VA facilities are unable to meet the demand for care from eligible veterans?

4. In general, if a veteran with a spinal cord injury cannot receive treatment in the Memphis VAMC, what alternatives are available in the community?

April 21, 1989

The Honorable Alan Cranston
Chairman, Committee on Veterans' Affairs
United States Senate
Washington, D.C. 20510-6375

Dear Senator Cranston:

Thank you for the opportunity to provide further information on the testimony I presented on April 6, 1989, before your committee. Per your request I am pleased to respond to your written questions. For the sake of expediency I have used the same format in order to identify my answers to your questions. My response is as follows:

1. The information you requested on individual veterans mentioned in my testimony is attached in the enclosed separate letter.

2. The most significant impact on funding shortfalls for prosthetics is generally seen at the end of each fiscal year. The veterans are directly affected by extended hospital stays while waiting for prosthetics to be funded for the next fiscal year in order for them to obtain necessary prosthetic equipment that they will need in their home environment. Additionally, the veteran's health is usually impaired by decubiti ulcers, infections, etc. ., when he must wait as an outpatient for cushions, wheelchairs, or other prosthetic items.

3. I feel that the community, both veterans and non-veterans who do not rely on the VA for health care, have no ideal what the lack of funding is doing to the veteran's who use this facility. If the community were required to provide health care to an equal number of patients seen at this facility, in addition to their current workload, they would not be able to cope with the demand that would be placed on them.

April 21, 1989

Response to Questions
PA~~GE 2~~.

In addition to the lack of capacity of the voluntary health care providers of Memphis, Tennessee/Shelby County, to care for the 260,000 veterans in the primary service area of the VA Medical Center in Memphis, Tennessee, there would be a strong financial disincentive to these voluntary health care providers to assume the financial liability for providing total health care service to the veterans' beneficiaries of this Medical Center; namely, the voluntary health care providers would only be interested in providing care to a relatively small percentage of the veterans who currently receive care at the VA Medical Center, as well as any other medical center. The vast majority of the veteran patients receiving care in the health care delivery system would present a significant financial drain or financial loss to the voluntary health care sector. If the Federal Government established financial arrangements with voluntary health care providers under a capitation system/preferred provider organization, the quality and quantity of health care provided to all veterans now receiving care would be significantly diminished. The VA health care delivery system can provide comprehensive health care services to veterans at less cost than the voluntary health care system. The majority of veterans whose health care costs would exceed funds provided for their care under a capitation system in the voluntary sector would either be denied essential health care services or would most likely receive fragmented substandard quality care,

In summary, the voluntary health care system in Memphis, Tennessee, has neither the capacity nor the financial incentive to provide comprehensive high-quality health care services to the veterans served by this VA Medical Center in a quality manner.

4. There are no facilities available in the local community to give comparable care to spinal cord injured veterans. There are no alternatives to thei SCI Center in Memphis.

I hope this information will assist you in providing your committee with a clear and concise picture of the crisis the lack of funding is having on the veterans we both serve.

Sincerely,

Richard E Woodworth

Richard Woodworth
Senior National Service Officer

QUESTIONS FROM SENATOR MURKOWSKI TO THRESA WILSON AND THE RESPONSES

QUESTIONS:

1. Over the last 1-2 years, has there been an increase in demand for inpatient and outpatient care - (Statistics at your facility) ?

(See Attachment A and B)

2. Out of the Category A Inpatients, how many are being treated for service connected injuries (Percentage) ?

(See Attachment C)

3. Where does your facility direct Category B & C patients to go for medical care, and are they getting care ?

(See Attachment D)

4. What steps would likely be taken at your facility if no additional money is given for Fiscal Year 1989 ?

We will operate within allocated funds.

5. At your facility, compare 1-2 years ago with:

   a) Inpatient Workload - (See Attachment A)

   b) Outpatient Workload - (See Attachment B)

   c) Staff Morale - (See Attachment E and F)

6. What programs/services have been reduced/cut at your facility because of the budget shortfall ?

(See Attachment G)

* NOTE: SUBMIT RESPONSE TO:

United States Senate
Committee on Veterans Affairs
Washington, D.C. 20510 - 6375

SUBMIT BY: April 14, 1989

Veterans Administration

INPATIENT WORKLOAD

ATTACHMENT A

FY87 (10/01/86-09/30/87)

	ADMISS	DISCH	ADC	ALOS	T/O %	BO %	PTS. TX
JOHN COCHRAN							
Med*	8046	7454	108	11**	575	94	7551
IM	17	93	3	8	300	68	97
SCI	2	21	1	10	190	50	22
Neuro	538	562	27	18	174	77	584
Surg	3827	3948	123	11	268	79	4074
SUBTOTAL	12430	12078	262	12**	384	85	12328
JEFFERSON BARRACKS							
PSYCH	3409	3434	182	21	157	73	3632
MED	2228	1964	67	12	164	70	2025
IM	5	583	69	41	71	90	636
SCI	206	230	30	47	63	75	264
SUBTOTAL	5848	6211	348	21	148	82	6557
HOSP TOTAL*	18278	18289	610	16**	250	84	18885
NHCU	256	197	100	185	16	96	351

*INCLUDES 4227 DIALYSIS VISITS (1 day)
**EXCLUDES DIALYSIS

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Veterans Administration

Inpatient Workload

ATTACHMENT A

FY 88 (10/1/87 - 9/30/88)

	ADMISS	DISCH	ADC	ALOS	T/O	BO %	PTS. TX
John Cochran							
Med	4154	3410	107	9	265	92	3524
IM	99	225	5	8	380	71	232
SCI	6	44	2	17	200	100	46
Neuro	561	646	20	11	270	83	663
Surg	3526	3750	120	12	261	81	3879
SUBTOTAL	8346	8075	254	12	265	90	8344
Jefferson Barracks							
Psych	3656	3716	184	18	169	84	3878
Med	2065	2011	67	12	251	80	2070
IM	10	297	34	42	74	55	314
SCI	175	204	31	56	55	78	236
SUBTOTAL	5906	6228	316	19	164	79	6498
HOSPITAL TOTAL	14252	14303	570	15	209	82	14842
NHCU	465	392	142	133	23	93	594

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Veterans Administration

INPATIENT WORKLOAD

ATTACHMENT A

Fiscal Year 1989

(TO DATE)

(10/1/88 - 3/31/89)	ADMISS	DISCH	ADC	ALOS	T/O%	BO%	PTS. TX
John Cochran							
Med.	1919	1771	116	12	254	88	1887
IM	112	139	8	10	290	80	149
SCI	6	19	2	19	158	100	20
Neuro	241	241	16	12	251	84	255
Surg	1848	1851	120	12	257	83	1974
SUBTOTAL:	4014	4021	262	12	256	85	4285
Jefferson Barracks						--	
Psych	1704	1662	189	21	147	91	1860
Med	855	906	70	14	216	85	974
IM	------	43	17	72	42	77	60
SCI	99	107	32	54	56	80	142
SUBTOTAL:	2770	2718	308	21	147	88	3036
Hospital Total:	6784	6739	570	15	197	86	7321
NHCU:	212	183	141	140	22	92	336

VA FORM JAN 1984 **7051b DATA SHEET**

U.S. GOVERNMENT PRINTING OFFICE : [illegible]

Veterans Administration

OUTPATIENT WORKLOAD ATTACHMENT B

Fiscal Year 1987		VISITS
(10/1/86 - 9/30/97)		
John Cochran		180610
Jefferson Barracks		73452
Hospital Total		254062
Fiscal Year 1988		
(10/1/87 - 9/30/88)		
John Cochran		188210
Jefferson Barracks		75332
Hospital Total		263542
*Fiscal Year 1989		
(To Date)		
(10/1/88 - 3/31/89)		
John Cochran		90546
Jefferson Barracks		32013
Hospital Total		122559

*Fiscal Year 1989 Workload Data subject to change due to continual updating.

VA FORM JAN 1984 **7051b DATA SHEET**

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Veterans Administration

ATTACHMENT C

CATEGORY A INPATIENTS - HOW MANY SERVICE CONNECTED

Fiscal Year 1989 (To Date) (10/1/88 - 2/28/89		AS DISCH.		TOTAL DISCH.		% SERVICE CONNECTED (CAT. A)
John Cochran		1012		3300		31%
Jefferson Barracks		715		2250		32%
Hospital Total		1727		5550		31%

VA FORM JAN 1984 **7051b DATA SHEET**

U.S. GOVERNMENT PRINTING OFFICE [illegible]

ATTACHMENT D

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Subj: QUESTIONAIRRE:  U.S. SENATE SUSPENSE 4 14 89 TO 00JB  12 Apr 89 15:09  17
Lines
From: MILLAS.BARBARA      in  IN  basket.
---------------------------------------------------------------------------------

In response to #1:  please indicate:  see #6 in/out-patient workload
statistics.

Effie, this is the response to #3 of the questionairre...this response was
prepared by Delores Bell, Assistant Chief SWS:

Where does your facility direct Category B&C patients to go for medical care
and are they getting care?

RESPONSE:  SWS directs patients to nearest community health care facility or
outpatient hospital clinic.  "We have not instituted a follow-up study, how-
ever, we plan to do some on the patients following through on referrals
in June 1989."


Press RETURN to continue or    to exit:
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ATTACHMENT E

Veterans
Administration

Memorandum

February 6, 1989

Medical Center Director, (00JB)

Attitude Survey

ALL STAFF

1. Your enthusiastic support of the Attitude Survey has been greatly appreciated by the Medical Center. Of the over 2,000 surveys sent out, 875 responses were received for analysis. Since so much data was accumulated, it has taken a significant amount of time to perform an in-depth analysis of this data. This information has been shared with management staff and recommendations have been made based on the answers you provided on the questionnaire.

2. The best liked and least liked aspects of employment have been categorized and are listed below. Actions have begun to accentuate the positive things and to provide potential solutions to negative aspects.

Best Liked Aspects

1. Patients and services provided to them
2. Co-workers
3. The work the employee does
4. Vacation and sick leave
5. Salary
6. Independence in practice of professional staff
7. Job security
8. Hours the employee works
9. The supervisor the employee has
10. The learning opportunities offered
11. Working for the government
12. The ability to improve things; challenges
13. The new equipment in the Clinical Addition
14. Tuition support
15. Clinical Addition
16. Promotion ability
17. Upper management
18. Positive feedback

Least Liked Aspects

1. The perceived decrease in quality of care due to lack of staffing and workload
2. Lack of appropriate management and lack of leadership concerns
3. Pay below community standards for similar positions
4. Lack of positive feedback and respect
5. Co-workers who have bad attitudes or do not work
6. Dead-end jobs, no advancement potential
7. Low morale
8. Shifts the employee works; hours worked

ATTACHMENT E

2.

Attitude Survey

Least Liked Aspects (Cont.)

9. Lack of supplies and equipment
10. Paperwork
11. Evaluation and promotion system
12. Lack of support services
13. Inadequate parking at John Cochran
14. Inability to have input in decisions
15. Politics, bureaucracy
16. Lack of appropriate training
17. Physicians' attitudes
18. Lack of communication

3. A discussion will be held at the February Employee Open Forum concerning the findings and actions resulting from these findings. Thank you again for your participation and cooperation.

JOHN T. CARSON

ATTACHMENT F

Veterans
Administration

Memorandum

January 10, 1989

Chairperson, Hospital Retention Committe, (118-JC)

Recommendations from Satisfaction Survey

Medical Center Director, (00-JB)

1. After careful analysis of the Satisfaction Survey, the Retention Committee has identified a significant amount of genuine employee concerns. In order to facilitate some timely responses the committee has targeted three areas of major concerns with recommendations in all areas.

2. Supervisory Recommendations:

a. The questionnaire identified significant management relation problems at all levels in both clinical and administrative services. There needs to be an internal review by services to identify their particular problem.

b. An annual management seminar inclusive of all levels of managers should be held with special emphasis of people skills and the institution of positive reinforcement programs.

c. All Service Chiefs should institute regularly scheduled staff meeting with their employees for communication and problem solving purposes.

d. The Performance Appraisal system needs to be handled positively with emphasis on the counseling and growth side of the program. An open forum should be held annually for all employees preceding the evaluation period. An attempt should be made to review all awards and to handle them more fairly perhaps by an Incentive Awards Committee.

e. It was more than evident that all levels of management (clinical and administrative) need to show concern about employees and patients. Spontaneous casual rounds by top management need to be instituted on a (one on one) basis with the focus of getting to the employees. JC Division could be accomplished by (1) floor at a time and JB Divison could be done (1) building at a time.

3. Support of VA Goals:

The majority of the respondents supported the goals of this medical center and were genuinely concerned about outside criticism. They take great pride in the quality of work they do feel the work is very useful.

There is an overwhelming concern for the decrease in quality of patient care which directly relates to an increase in workload due to more complex patients waiting longer for hospitalization and an increased patient turnover without appropriate staffing support. The employees identified a resulting low morale and negative attitudes from increased frustration in accomplishing daily workload.

ATTACHMENT F

2.

Recommendations from Satisfaction Survey

Recommendations:

a. A review needs to be done of all current programs, workloads, accomplishments during past 3-6 months; and management needs to make appropriate programmatic adjustments, cuts, and redistribution of staff.

b. There is an identified need for more positive simple employee recognition. A set of mock situations would be created by this committee with the assistance of Medical Media, role play would be done by supervisors and staff people with the initial program presented to Director's Staff Meeting, followed by Open Forums, videotaping and mass communication of the program.

c. The quality circles currently being utilized in Engineering Service could also be presented in the above format.

d. Since work group cohesiveness was emphasized by many staff groups; these groups should be spotlighted in the Weekly Bulletin or Employee Newsletter.

e. Posters in the entrances of each division should publicize the Employee of the Month and what was done to get this award.

f. An Incentive Awards Fund could be established by each service to spotlight a Service Employee of the Month program with prizes and publicity in the Weekly Bulletin in a timely manner.

4. Veteran Administration's Reputation as an Employer:

a. In order to enhance VA's reputation as an employer, the VA should provide community education programs to the professional community.

b. This VA Medical Center currently conducts a community service oriented public information program. There is an obvious need to institute a true public relation program with a real community focus. This program needs to focus on improving our reputation within the community.

RUTH HUNTER, R.N.

ATTACHMENT G

6. What programs/services have been reduced/cut at your facility because of the budget shortfall?

In addition to the elimination of the Clinical Nurse Outreach Program in November 1988, we have instituted an on-site review of all patients in categories "C," "B," and are continuing with stable "A/NSC"; and if clinical need for continued care does not exist, patients are discharged. If discharged, our veterans are given appropriate instructions to obtain follow-up care from alternate community sources. We have not terminated any clinically relevant programs. Our community nursing home care program census has a planned census reduction of 92 versus assignment by curtailing placements and increased use of our NHCU for long-term placements. We have also reviewed pharmacy expenditures and have started limiting prescribing to the high-cost items, i.e., non-steroidals. We have controlled beneficiary travel and issuance of prosthetic devices within eligibility guidelines.